# Arizona Medical Board

9545 East Doubletree Ranch Road • Scottsdale, Arizona 85258
Home Page: http://www.azmd.gov
Telephone (480) 551-2700 • Fax (480) 551-2704 • In-State Toll Free (877) 255-2212

## DRAFT MINUTES FOR REGULAR SESSION MEETING
## Held at 9:30 a.m. on April 11, 2007 and 8:00 a.m. on April 12, 2007, 9535 E. Doubletree Ranch Road · Scottsdale, Arizona

***Board Members***

William R. Martin III, M.D., Chair
Douglas D. Lee, M.D., Vice Chair
Dona Pardo, Ph.D., R.N., Secretary
Patrick N. Connell, M.D.
Dan Eckstrom
Robert P. Goldfarb, M.D., F.A.C.S.
Patricia Griffen
Ram R. Krishna, M.D.
Lorraine L. Mackstaller, M.D.
Paul M. Petelin Sr., M.D.
Germaine Proulx
Amy J. Schneider, M.D., F.A.C.O.G.

### Executive Director's Report

Executive Director and Agency Office Reports

Timothy Miller, J.D., Executive Director provided the Board with performance measures to inform the Board of what is going on inside the agency along with statistics from the different offices inside the agency.

In the Board's Licensing Office, overall increase of the time it takes to process licenses was 2.5 percent. The State's growth in population was 3.5 percent. The physician growth is not keeping up with population growth rate. There is a large distinction from the number of licensees rather than the number of who are actively practicing in the State.

The Board's Office of Investigations has reduced the number of open investigations and the amount of time taken to finish them. Board Staff was recently complimented by auditors in Washington State for the Board's process for completing investigations. The Board also received a compliment on its strategic plan for its realistic goals and measurements. Mr. Miller informed the Board that he will be presenting the strategic plan to the Board at their next regularly scheduled meeting in June 2007.

The Board's Investigational Review Office currently has 45 cases awaiting adjudication. The average time to close an investigation is 127 days.

Mr. Miller stated that most of the agency's backlog is due to scheduling Formal Hearings with the Office of Administrative Hearings. There has recently been discussion as to the roles and responsibilities of the Assistant Attorney Generals (AAGs). Currently, the Board's AAGs have been responding to Judicial Review Actions filed in Superior Court. Staff is currently working to see where they might be able to help with this.

In regard to the implementation of the agency's new database, the vendor is already developing the screens for the Licensing Office. The agency had hoped for a July completion date but is now anticipating an August completion. Mr. Miller informed the Board that the agency is a little more demanding on what is needed and that is why the process has taken so long thus far.

Goodman Arizona Medical Board Weekly Legislative Report – Legislative Update (March 9, 2007)

The State's Legislator has been busy with behind the scene budget. They are holding special meetings to do their own investigations to address problems within the Veteran's Administration.

The following Bills were brought to the Board's attention for informational purposes and an update on where they are located in the House/Senate:

HB 2115 - Non Disciplinary CME – Passed Senate Health
HB 2125 - Makes various to the medical examiner statutes – Senate Committee Assignment
HB 2136 - Exempts from Pharmacy Board regulation the manufacturing of nonprescription drugs by a person who is not a pharmacist and who holds the required permit issued by the Board – Senate Committee Assignment
HB 2139 - Definition for private practice for those exempt from having a DHS license – Senate Committee Assignment
HB 2221- Appropriates money to designated cancer research health care institutions in Maricopa and Pima counties to perform research, treatment, education and preventive research into cancers that are unique to women – Passed House Human Services
HB 2256 - Medical therapy management services – Passed House Health
HB 2357 - Terminally ill patient assistance for control of suffering – Committee Assignment
HB 2436 - Requires that the elements of proof shall be established as clear and convincing evidence in matters relating to a health care provider's failure to follow the accepted standard of care – Awaiting Committee Assignment
HB 2438 - Requires the Arizona State Board of Pharmacy to establish a controlled substances prescription monitoring program – Passed House Health
HB 2516 - Eliminates the restrictions on optometrists' ability to prescribe selected antihistamines for patients – Passed House Health
HB 2563 - Prohibits the state ombudsman citizens aide from accessing those protected by federal law and information on government-owned facilities that are classified as critical infrastructure – Senate Committee Assignment
HB 2572 - Allows a qualified patient to make a written request for medication to end the patient's life – Committee Assignment
HB 2578 - Restricts health businesses on disclosing an individual's identifiable health information to a site outside the U.S. unless consent is given by the individual – Committee Assignment
HB 2581 - Picture ID on licenses issued by a State agency – Committee Assignment
HB 2629 – Requires health insurance and disability insurance providers to provide coverage for a pregnant woman to have genetic testing for thrombophilia if the testing is ordered by a licensed physician – Committee Assignment
HB 2641 – Allows a judge to grant a pregnant minor permission to have an abortion without parental consent – Retained House COW
HB 2649 – Requires the county medical examiner to retain certain information from each autopsy performed – Committee Assignment
HB 2736 – Pharmacies and antiepileptic medication – Committee Assignment
HB 2761 – Mandatory reporting to the MVD – Committee Assignment
HB 2770 – Appropriates money to the Department of Health Services for nonembryonic human stem cell research and for a repository for storage of nonembryonic human stem cells – Passed House Appropriations
HCR 2044 – Recognizes the importance of health care planning and proclaims the week of November 4, 2007 Health Care Decisions Week – Senate Committee Assignment
SB 1015 – Requires certain health care professionals in a health care institution to cooperate with police for investigation of intoxicated patients – Passed House Natural Resources and Public Safety
SB 1032 – Requires the statutory elements of proof for medical malpractice cases related to certain emergency circumstances to be established by clear and convincing evidence – Held House Health
SB 1100 – Allows nurse practitioners to perform work as independent medical reviewers – Passed House Health
SB 1173 – Prohibits a health care business from transmitting individually identifiable health information to a site outside of the country except under specific conditions, including obtaining a signed consent form from the individual – Passed Senate Health
SB 1248 – Arizona Health Care Cost Containment System (AHCCCS) shall maintain public records in computerized form regarding psychiatric medications administered to children – Failed Senate Health
SB 1249 – Medication disclosure when prescribing psychotropic medications – Committee Assignment
SB 1294 – Establishes the Board of Surgical Assistants which is to be administered by the Arizona Medical Board – Passed Senate Health
SB 1374 – Appropriate money to the Department of Health Services for valley fever research – Committee Assignment
SB 1385 – Appropriate money to the AHCCCS administration for human papilloma virus vaccine for all female clients who are at least twenty-one but not more than twenty-six years of age – Committee Assignment
SB 1398 – Appropriate money to AHCCCS administration for expansion of graduate medical education – Committee Assignment
SB 1399 – Appropriate money to AHCCCS administration for continuation of the health insurance flexibility and accountability patents program – Committee Assignment
SB 1406 – Appropriate money to university medical programs – Committee Assignment
SB 1558 – Appropriate money to university medical programs – Passed Senate Health
SB 1561 – AHCCCS physician recruitment fund – Committee Assignment
SB 1579 – Appropriate money to DHS for graduate medical education residencies – Committee Assignment
SR 1002 – Commends health care professionals for contracting with Triwest Healthcare Alliance and supporting military families during the war on terror – Held Senate Health

## Chair's Report

William R. Martin, III, M.D. presented a plaque in recognition of Sharon B. Megdal, Ph.D. for her service on the Board from January 1999 to April 2007. Dr. Martin thanked her for helping the Board to fulfill its mission to protect the public.

Dr. Martin recognized the Board's enthusiasm in continuing to help the citizens in the state and suggested the Board should be more proactive.

Discussion and Creation of Committees: Guidelines, Communications, Education, FSMB, Oversight, Advocacy, Rules

William R. Martin, III, M.D. stated that the Committees may be amended in any way the Board chooses and this was just a starting point. He stated he wanted to have some concrete items completed so that the Board can continue to move forward at their offsite meeting. The Board is no longer in a position of having to defend on a daily basis and can now focus on other things. Dr. Martin noted that the Board had previously discussed these items but never really found a way to put their thoughts into action.

Dr. Martin noted that the PA Supervision Committee and Office Based-Surgery Committee already exists and have on-going work to be completed.

Dr. Martin proposed the following four Subcommittees:

Guideline Development Committee:
Ophthalmology
Urgent Care
Integrative or Complementary and Alternative Medicine
Delegation of medical duties to licensed or unlicensed staff

This would assist in addressing these type issues when brought before them. The information will already be out there for the physicians and attorneys to be aware of the Board's expectations.

Communications and Education Committee:
Internet website design
Integration and Management
CME credits for on-line registration for medical licensure
Arizona Medical Board "Road Show"/Speakers Bureau
On-site "No Penalty" practice review
Telemedicine

This is a way to encourage physicians to study and review the statutes and be more familiar with them.

Lorraine Mackstaller, M.D. volunteered to join this Committee and felt this was a better way to communicate to the physicians.

FSMB Liaison Committee:
License Portability
USMLE
Multi-state telemedicine license

Dr. Martin felt this was a way to educate them instead of reacting to any changes that are told to them and to be on top to know and help guide them.

Area of Oversight:
Development/Implementation
Physician Health Program
Monitored Aftercare Program
Physician Assessment and Clinical Evaluation (PACE)
Betty Ford and other drug/substance abuse programs
Sexually Recovery Institute

There are portions of the above listed programs that are completely confidential. Dr. Martin felt that if the Board is ultimately approving how these programs are run then Board Members should have some oversight into their development.

Dr. Martin proposed Board Members volunteer for one of two areas that they feel they can make the most impact or are more passionate about and also encouraged Members to go where the list might not be complete

The Board anticipates the Committees to be mostly done telephonically and can meet once or twice a month.

Ram R. Krishna, M.D. commended Dr. Martin for taking the lead and felt it was an excellent idea. Dr. Krishna suggested the Board to educate the physicians and at the same time still protect the public.

Patrick N. Connell, M.D. wondered if doing all four Committees simultaneously would be effective and suggested that the Board do two Committees at a time.

Timothy Miller, J.D., Executive Director informed the Board that Staff coordinates stakeholder interest so that they may have the opportunity to provide their input.

## Approval of Minutes

**MOTION: Ram R. Krishna, M.D. moved to approve the February 7, 2007 Special Meeting Minutes, Including Executive Session and the February 7-8, 2007 Regular Session Meeting Minutes, Including Executive Session.**
**SECONDED: Dona Pardo, Ph.D., R.N.**
**Vote: 12-yay, 0-nay, 0-abstain, 0-recuse, 0-absent.**
**MOTION PASSED.**

## ADVISORY LETTERS

| NO. | CASE NO. | COMPLAINANT v PHYSICIAN | | LIC. # | RESOLUTION |
|---|---|---|---|---|---|
| 1. | MD-05-0796A | AMB | JOHN G. CORCORAN, M.D. | 12377 | Advisory Letter for altering medical records and 10 hours non-disciplinary CME in medical record keeping. |
| 2. | MD-06-0513C | I.R. | QUIRINO B. VALEROS, M.D. | 9962 | Reject the Advisory Letter and Invite the physician for a Formal Interview. |

IR was present and spoke during the Call to Public on behalf of the patient, her husband. Her husband put in six different requests for medical care with the same complaint. Her husband terminated his care with Dr. Valeros because he knew nothing would be done just like the other requests that went ignored. She felt that given the location of the health care facility, the physician did not take her husband seriously.

**MOTION: Lorraine Mackstaller, M.D. moved to invite the physician for a Formal Interview.**
**SECONDED: Patricia R.J. Griffen**
**Vote: 10-yay, 1-nay, 1-abstention, 0-recuse, 0-absent.**
**MOTION PASSED.**

| NO. | CASE NO. | COMPLAINANT v PHYSICIAN | | LIC. # | RESOLUTION |
|---|---|---|---|---|---|
| 3. | MD-06-0806A | AMB | KETAN G. JANI, M.D. | 30908 | Advisory Letter for falsely representing he was Board Certified in Sleep Medicine. |
| 4. | MD-06-0232A | S.K. | ROY R. GETTEL, M.D. | 11015 | Advisory Letter for failure to document a pre and post-operative radial nerve examination. |

Paul M. Petelin, Sr., M.D. asked for clarification as to why Board Staff recommended an Advisory Letter to be issued to Dr. Gettel. Dr. Petelin also asked if this case was in any relation to a Decree of Censure that was previously issued.

Christine Cassetta, Board Legal Counsel informed Dr. Petelin that if he felt this were a case where disciplinary action is warranted, then the physician could be invited for a formal interview. Dr. Petelin stated that if the Board feels disciplinary is not necessary in this case, he was willing to remove his objection to the Advisory Letter.

**MOTION: Paul M. Petelin, Sr., M.D. moved to accept the Advisory Letter.**
**SECONDED: Douglas D. Lee, M.D.**
**Vote: 11-yay, 0-nay, 0-abstain, 0-recuse, 1-absent**
**MOTION PASSED.**

| NO. | CASE NO. | COMPLAINANT v PHYSICIAN | | LIC. # | RESOLUTION |
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| 5. | MD-06-0507A | AMB | MERL J. PEACHEY, M.D. | 5375 | Reject the Advisory Letter and return for further investigation. |

Paul M. Petelin, Sr., M.D. recused himself from this case.

Erica Bouton, Senior Investigator briefly summarized the case at the request of the Board. During the course of the investigation, Dr. Peachey was ordered by Board Staff to undergo an evaluation. The results stated that he is not a threat to the public. She informed the Board that Dr. Peachey is currently practicing. Also during the course of the investigation, Dr. Peachey told Board Staff that his behavior was due to his depression. Robert P. Goldfarb, M.D. was concerned that Dr. Peachy would exhibit similar behavior in the future if he is depressed again.

Christine Cassetta, Board Legal Counsel stated that Board records indicate Dr. Peachey does have an active license to practice in Arizona, but he does not have a current office address of record.

Timothy Miller, J.D., Executive Director informed the Board that Staff has recently received information that could affect the Board's final decision in this case. Mr. Miller requested the Board pull this case and send it back for further investigation.

**MOTION: Robert P. Goldfarb, M.D., FACS moved to return this case for further investigation.**
**SECONDED: Patrick N. Connell, M.D.**
**VOTE: 11-yay, 0-nay, 0-abstain, 1-recuse, 0-absent**
**MOTION PASSED.**

| NO. | CASE NO. | COMPLAINANT v PHYSICIAN | | LIC. # | RESOLUTION |
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| 6. | MD-06-0358A | L.N. | STEPHEN O. MORRIS, M.D. | 10800 | Reject the Advisory Letter and return for further investigation. |

LN was present and spoke during the Call to Public. She stated that the family of the patient felt that Dr. Morris' negligence led to the demise of patient JPM. LN stated that at no time did Dr. Morris order tests for JPM, nor did he discontinue prescribing narcotics after JPM had been institutionalized twice due to the medication he was taking. The patient's family felt if he had been monitored more closely and had tests done, it would have altered Dr. Morris' plan for treatment. LN noted that Dr. Morris had previously been issued a Decree of Censure in 2003 for his "same lack of care" and requested that the Board revoke Dr. Morris' license to practice medicine in the State of Arizona.

Mark Nanney,M.D., Chief Medical Consultant briefly summarized the case for the Board. Dr. Nanney stated that the Staff Investigational Review Committee (SIRC) recognized that Dr. Morris' prescribing was a problem, but had limited resources as to the medical consultant report. William R. Martin, III, M.D. asked if there were a way to obtain additional opinions. Mr. Miller stated the Board has two options: this case can either be referred for further investigation and brought back to the Board, or the Board can bring Dr. Morris in for a Formal Interview.

Dona Pardo, Ph.D., R.N. stated that Dr. Morris has a prior Board history of a Decree of Censure from 2002 for what seemed to be the same issue. The Board noted that the incident involving this case had happened in 2005.

**MOTION: Douglas D. Lee, M.D. moved to reject the Advisory Letter and return this case for further investigation.**
**SECONDED: Robert P. Goldfarb, M.D.**
**Vote: 11-yay, 0-nay, 0-abstain, 0-recuse, 1-absent.**
**MOTION PASSED.**

| NO. | CASE NO. | COMPLAINANT v PHYSICIAN | | LIC. # | RESOLUTION |
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| 7. | MD-06-0429A | B.K. | NADIA C. SLYSH, M.D. | 28682 | Dismiss |

Nadia C. Slysh, M.D. was present and spoke during the Call to Public. Dr. Slysh stated that her office prides themselves on full eye exams and feels that all patients who visit her office receive all the attention they need. She also stated that the day this patient visited her office for an eye exam, if there were something there to see, she would have seen it.

Dona Pardo, Ph.D., R.N., was concerned and felt it were egregious that Dr. Slysh missed the diagnosis. Paul M. Petelin, Sr., M.D. noted that nine months passed before the melanoma was discovered in this patient and Dr. Slysh performed a very adequate exam.

**MOTION: Paul M. Petelin, Sr., M.D. moved to reject the Advisory Letter and dismiss this case.**
**SECONDED: Robert P. Goldfarb, M.D.**
**Vote: 11-yay, 0-nay, 0-abstain, 0-recuse, 1-absent.**
**MOTION PASSED.**

| NO. | CASE NO. | COMPLAINANT v PHYSICIAN | | LIC. # | RESOLUTION |
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| 8. | MD-06-0521A | AMB | DAVID W. CAMPBELL, M.D. | 9422 | Advisory Letter for inappropriate prescribing and for failure to maintain medical records. |

Amy J. Schneider, M.D., F.A.C.O.G., stated she was concerned that Dr. Campbell's status is retired but he is still prescribing control substances. Douglas D. Lee, M.D. stated that Dr. Campbell retired in 1999 and these prescriptions were written in 2005 and again in 2006. Ram R. Krishna, M.D. stated that this was a one time offense and he is no longer practicing. Lorraine Mackstaller, M.D. asked what would be considered to be 'adequate medical records' when a physician who is retired is still prescribing. Christine Cassetta, Board Legal Counsel replied by stating the record is adequate if it complies with the statutory requirements.

**MOTION: Ram R. Krishna, M.D. moved to accept the Advisory Letter.**
**SECONDED: Douglas D. Lee, M.D.**
**Vote: 11-yay, 0-nay, 0-abstain, 0-recuse, 1-absent.**
**MOTION PASSED.**

| NO. | CASE NO. | COMPLAINANT v PHYSICIAN | | LIC. # | RESOLUTION |
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| 9. | MD-06-0872A | AMB | ALAN C. SACKS, M.D. | 9475 | Advisory Letter for failure to adhere to the Board Order |

| NO. | CASE NO. | COMPLAINANT v PHYSICIAN | | LIC. # | RESOLUTION |
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| | | | | | requirement that the chaperone sign, date and legibly print her name in each patient chart. |

Dona Pardo, Ph.D., R.N. stated that in the past, physicians were issued disciplinary action for violating a Board Order. Dr. Pardo also stated that Dr. Sacks might not have taken the Order seriously, and asked what good is issuing a Board Order if physicians do not adhere to them. Mark Nanney, M.D., Chief Medical Consultant informed the Board that chaperones were indeed present, the deviation is that the chaperone failed to sign Dr. Sacks' chart verifying that a chaperone was present. Douglas D. Lee, M.D. stated that Dr. Sacks should be given the benefit of the doubt. The Board determined that it is the physician's responsibility to have the chaperone sign the chart verifying her presence.

**MOTION: Ram R. Krishna, M.D. moved to accept the Advisory Letter.**
**SECONDED: Patricia R.J. Griffen**
**Vote: 11-yay, 0-nay, 0-abstain, 0-recuse, 1-absent.**
**MOTION PASSED.**

| NO. | CASE NO. | COMPLAINANT v PHYSICIAN | | LIC. # | RESOLUTION |
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| 10. | MD-06-0367A | K.M. | DAVID A. PEDERSEN, M.D. | 23255 | Invite the physician for a Formal Interview. |

NB was present and spoke during the Call to Public on behalf of the deceased patient, her father. She stated that Dr. Pedersen never followed up with her father after his surgery and her father was dying of septic shock. She stated that she and her family will never know if the outcome could have been different. After he father's funeral, NB and her family tried to understand, but Dr. Pedersen made no attempt to contact the patient's family.

Paul M. Petelin, Sr., M.D., disagreed with the internal medical consultant. He stated it was the physician's responsibility to see the patient everyday. By his own admission, Dr. Pedersen stated he sees patients only three times a week. The Board wondered what powers physicians should delegate to physician extenders. The Board wondered if the complication could have been prevented had Dr. Pedersen done the post operative rounds himself. They agreed that the outcome would likely not have changed, but perhaps the complication could have been treated earlier.

Robert P. Goldfarb, M.D. noted that many times the Board has heard of physicians who do not do the follow up and their delegate their post operative care to their staff.

**MOTION: Paul M. Petelin, Sr., M.D. moved to invite the physician for a Formal Interview.**
**SECONDED: Lorraine Mackstaller, M.D.**
**Vote: 11-yay, 0-nay, 0-abstain, 0-recuse, 1-absent.**
**MOTION PASSED.**

| NO. | CASE NO. | COMPLAINANT v PHYSICIAN | | LIC. # | RESOLUTION |
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| 11. | MD-06-0373A | D.F. | JAMES L. ROBROCK, M.D. | 16209 | Advisory Letter for inadequate medical records. This matter did not rise to the level of discipline. |

Amy J. Schneider, M.D., F.A.C.O.G. stated that she was concerned with Dr. Robrock's history with the Board. Currently Dr. Robrock is under a practice restriction.

**MOTION: Amy J. Schneider, M.D., F.A.C.O.G. moved to accept the Advisory Letter.**
**SECONDED: Douglas D. Lee, M.D.**
**VOTE: 11-yay, 0-nay, 0-abstain, 0-recuse, 1-absent.**
**MOTION PASSED.**

| NO. | CASE NO. | COMPLAINANT v PHYSICIAN | | LIC. # | RESOLUTION |
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| 12. | MD-06-0417A | AMB | GERALD DORROS, M.D. | 25778 | Advisory Letter for violating a Federal statute. This matter did not rise to the level of discipline. |
| 13. | MD-06-0765A | AMB | WILLIAM L. JOBE, M.D. | 31141 | Advisory Letter for an action taken by another state for his failure to properly read an x-ray. |
| 14. | MD-06-0372A | S.W. | HITENDRA D. CHAUHAN, M.D. | 24680 | Advisory Letter for inadequate charting of indications for a second surgery and for failure to obtain informed consent for a second procedure. This matter did not rise to the level of discipline. |
| 15. | MD-06-0675A | AMB | BILAL A. MIAN, M.D. | 25609 | Advisory Letter for failure to mention a sponge that was visible on x-ray. The violation is a minor or technical violation. |

Amy J. Schneider, M.D., F.A.C.O.C. stated that she was concerned the consultant who reviewed this case was not a radiologist. She asked if Staff should have a radiologist review this case before going forward with the adjudication process. Ingrid Haas, M.D., Internal Medical Consultant stated that she did review the films but is not a radiologist. She stated to the Board that if they

felt it would change their decision, they can forward it to a radiologist to review. Dr. Schneider stated that she thinks it would be more egregious if a radiologist were to review and opine on the case.

Paul M. Petelin, Sr., M.D. noted that during the settlement and by his own admittance, Dr. Mian stated he did miss it. Robert P. Goldfarb, M.D. noted that the Board issued Advisory Letters for the same in the past.

**MOTION: Lorraine Mackstaller, M.D. moved to accept the Advisory Letter.**
**SECONDED: Paul M. Petelin, Sr., M.D.**
**VOTE: 11-yay, 0-nay, 0-abstain, 0-recuse, 1-absent.**
**MOTION PASSED.**

| NO. | CASE NO. | COMPLAINANT v PHYSICIAN | | LIC. # | RESOLUTION |
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| 16. | MD-06-0045A | DEPT. OF VETERANS AFFAIRS | IFAT A. SHAH, M.D. | 31786 | Advisory Letter for improper reading of pathology slides and 20 hours non-disciplinary CME in pathology slide review. |

Ifat A. Shah, M.D., was present and spoke during the Call to Public. Dr. Shah stated that there have been no complaints against him since 2003. He stated that the allegations in this case were perpetrated from the facility's Chief of Staff. He stated that prior to any due process, the facility decided (I CHANGED THIS B/C OTHERWISE IT LOOKS LIKE HE'S SAYING THE BOARD'S DECISION WAS MADE W/O DUE PROCESS) decision was made that he would be punished. Dr. Shah claimed that he was unable to consult with any of his colleagues prior to making his diagnosis in this case. Dr. Shah stated that when thinking back on the action taken against him, he was reminded of two others who were treated the same in the past, Socrates and Jesus Christ.

Lorraine Mackstaller, M.D. noted that there were a few errors made, but was in support of an Advisory Letter.

**MOTION: Lorraine Mackstaller, M.D. moved to accept the Advisory Letter.**
**SECONDED: Douglas D. Lee, M.D.**

Ram R. Krishna, M.D. noted that there were several incidences within his record and spoke against the motion. William R. Martin, III, M.D. stated that he felt this case might warrant disciplinary action.

The Board asked if Dr. Shah is currently still reading patient slides. Vicki Johansen, Senior Investigator stated that she had spoken with Dr. Shah the day before in which he stated he is retiring the day of this meeting. She told the Board that she will be sure to follow up with his license status.

The Board wondered that if the outcome of this case would be different if Staff could obtain all the pertinent evidence needed. Mark Nanney, M.D., Chief Medical Consultant informed the Board that since Staff did not have the records, they can not determine if there was any harm.

Paul M. Petelin, Sr., M.D. stated that since the Board has the ability to issue non-disciplinary CME, he asked the Board Members if they should require Dr. Shah to obtain them when issuing the Advisory Letter.

William R. Martin, III, M.D. stated that the Board should issue Dr. Shah the Advisory Letter with 20 hours non-disciplinary CME in pathology slide review.

**AMENDED MOTION: Lorraine Mackstaller, M.D. moved to accept the Advisory Letter with 20 hours non-disciplinary CME in pathology slide review.**
**SECONDED: Douglas D. Lee, M.D.**

**Vote: 11-yay, 0-nay, 0-abstain, 0-recuse, 1-absent.**
**MOTION PASSED.**

| NO. | CASE NO. | COMPLAINANT v PHYSICIAN | | LIC. # | RESOLUTION |
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| 17. | MD-05-1071A | AMB | DANIEL M. LIEBERMAN, M.D. | 28519 | Return for further investigation. |

Daniel M. Lieberman, M.D. was present and spoke during the Call to Public. Dr. Lieberman stated that this case involved a complicated type of treatment and the outcome was unfortunately a bad one. He stated that Dr. Hamilton was his witness and was the most trained. Dr. Hamilton reviewed the case and opined that Dr. Lieberman did not make an error. Dr. Lieberman communicated to the Board that an Advisory Letter is significant to him and asked the Board to consider all the material and ultimately dismiss his case.

Robert P. Goldfarb, M.D. asked Board Staff if Dr. Lieberman's billing records were obtained. Erica Bouton, Senior Investigator stated that Staff was unable to obtain the records because the billing records were saved on an old system and were unprintable. Robert P. Goldfarb, M.D. stated Board Staff should go through the patient's insurance company to obtain them. Dr. Goldfarb

wanted to know if Dr. Lieberman billed for more than just placing the frame on the patient. Dr. Goldfarb told Board Staff that the CPT codes that were charged on that day are needed from the insurance company.

**MOTION: Robert P. Goldfarb, M.D. moved to return the case for further investigation.**
**SECONDED: Douglas D. Lee, M.D.**
**MOTION PASSED.**

| NO. | CASE NO. | COMPLAINANT v PHYSICIAN | | LIC. # | RESOLUTION |
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| 18. | MD-06-0427A | D.O. | PAUL W. LA PRADE, M.D. | 13306 | Advisory Letter for inappropriately recommending spinal surgery and for inadequate medical records and 15 hours non-disciplinary CME in medical record keeping. |

Paul W. La Prade, M.D. was present and spoke during the Call to Public. He believed he was overly aggressive with this patient. He does not plan to do the same surgery again on a patient in the same situation that led to this case.

Robert P. Goldfarb, M.D. briefly summarized the case for the Board. Gerald Moczynski, M.D., Medical Consultant explained the procedure to the Board. The Board reviewed the films of the patient that were submitted during the course of the investigation. Dr. Goldfarb agreed to the Advisory Letter.

Paul M. Petelin, Sr., M.D. was concerned with Dr. La Prade's prior Board history.

Dona Pardo, Ph.D., R.N. wanted to see Dr. La Prade obtain some CME in recordkeeping or be issued disciplinary action since he had previously been cited for poor recordkeeping. Dr. Goldfarb agreed and felt Dr. La Prade should need to obtain non-disciplinary CME in recordkeeping.

**MOTION: Douglas D. Lee, M.D. moved to accept the Advisory Letter for inappropriately recommending spinal surgery and for inadequate medical records and 15 hours non-disciplinary CME in medical record keeping.**
**SECONDED: Robert P. Goldfarb, M.D.**
**Vote: 11-yay, 0-nay, 0-abstain, 0-recuse, 1-absent.**
**MOTION PASSED.**

| NO. | CASE NO. | COMPLAINANT v PHYSICIAN | | LIC. # | RESOLUTION |
|---|---|---|---|---|---|
| 19. | MD-06-0479A | E.R. | GARY W. HALL, M.D. | 12977 | Advisory Letter for failure to perform a dilated fundal examination in the postoperative period. |
| 20. | MD-06-1013A | AMB | UNEN DU HSU, M.D. | 8373 | Advisory Letter for violating a Board Order and prescribing Soma on one occasion, shortly after an Interim Order restricting his practice went into effect. |

Dona Pardo, Ph.D., R.N. was concerned with Dr. Hsu's violation of the Board order.

**MOTION: Lorraine Mackstaller, M.D. moved to accept the Advisory Letter.**
**SECONDED: Patrick N. Connell, M.D.**
**Vote: 8-yay, 2-nay, 0-abstain, 1-recuse, 1-absent.**
**MOTION PASSED.**

| NO. | CASE NO. | COMPLAINANT v PHYSICIAN | | LIC. # | RESOLUTION |
|---|---|---|---|---|---|
| 21. | MD-06-0486A | M.H. | RICHARD L. SMITH, M.D. | 3360 | Advisory Letter for failure to retain records for the statutory period. There is insufficient evidence to support disciplinary action. |
| 22. | MD-06-0560A | K.P. | JANELLE A. Y. ENGEL, M.D. | 11923 | Advisory Letter for improper evaluation and biopsy on a mass identified on MRI and for failure to obtain the appropriate studies of the mass on the MRI. The violation is a minor or technical violation that is not of sufficient merit to warrant disciplinary action. |
| 23. | MD-06-0682A | AMB | CAROL J. NEWMYER, M.D. | 18661 | Advisory Letter for an incomprehensible operative note. The violation is a minor or technical violation. The violation is a minor or technical violation that is not of sufficient merit to warrant disciplinary action. |
| 24. | MD-06-0525A | AMB | MICHAEL J. ROSEN, M.D. | 21267 | Offer the physician a consent agreement for a Letter of Reprimand. If the physician declines, invite him for a Formal Interview. |

Paul M. Petelin, Sr., M.D. felt that Dr. Rosen's statement in his response to the Board investigation was not entirely believable and questioned whether Dr. Rosen was trying to negotiate a deal with the government to pay off his loans. Dona Pardo, Ph.D., R.N. asked if the Board had the option of ordering a civil penalty with an Advisory Letter. Christine Cassetta, Board Legal Counsel stated that a civil penalty is a disciplinary action and could not be included with the Advisory Letter. If the Board felt the case warranted disciplinary action, it could issue a Letter of Reprimand with a civil penalty.

**MOTION: Patrick N. Connell, M.D. moved to offer the physician a consent agreement for a Letter of Reprimand. If the physician declines, invite him for a Formal Interview.**
**SECONDED: Paul M. Petelin, Sr., M.D.**
**VOTE: 11-yay, 1-nay, 0-abstain, 0-recuse, 0-absent.**
**MOTION PASSED.**

Robert P. Goldfarb, M.D. asked if the Board were to give Dr. Rosen a civil penalty for not paying his loan, would Dr. Rosen excluded from Medicare and Medicaid. Ram R. Krishna, M.D. stated that civil penalty would be a problem and thought a Letter of Reprimand would be fine. Lorraine Mackstaller, M.D. stated she did not know if that was really the Board's job. She noted that the Government had already sanctioned Dr. Rosen.

William R. Martin, III, M.D. asked if it would better serve the public to raise the level of action against Dr. Rosen. Paul M. Petelin, Sr., M.D. felt it disturbing that Dr. Rosen would go through this for several years for personal gain and wondered if he is willing to do something like this later on.

| NO. | CASE NO. | COMPLAINANT v PHYSICIAN | | LIC. # | RESOLUTION |
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| 25. | MD-06-0641A | C.F. | KENT V. CAREY, M.D. | 13998 | Advisory Letter for failure to document a neck examination. |

Paul M. Petelin, Sr., M.D. stated that he would hate to think that patients are discriminated against because of their age. Dr. Petelin wondered if the outcome would have been different had Dr. Carey checked the patient's head. Patrick N. Connell, M.D., stated that the standard of care, with that kind of fall, a physician should not just clear the patient. Dr. Connell stated that Dr. Carey admitted to it. William R. Martin, III, M.D. stated that regardless of this case rising to discipline or not, the Board should consider the harm to the patient. Robert P. Goldfarb, M.D. informed the Board that for many patients presenting to an Emergency Department usually do not have CT scans done. The Board noted that the patient went back to Dr. Carey with a stroke and the missed the fracture probably did not contribute to the stroke.

**MOTION: Paul M. Petelin, Sr., M.D. moved to accept the Advisory Letter.**
**SECONDED: Patrick N. Connell.**
**12-yay, 0-nay, 0-abstain, 0-recuse, 0-absent.**
**MOTION PASSED.**

## REVIEW OF ED DISMISSALS

**MOTION: Lorraine Mackstaller, M.D., moved to uphold the Executive Director's dismissals for cases 1, 3, 4, 5, 7, 8, and 9.**
**SECONDED: Patrick N. Connell**
**Vote: 12-yay, 0-nay, 0-abstain, 0-recuse, 0-absent.**
**MOTION PASSED.**

| NO. | CASE NO. | COMPLAINANT v PHYSICIAN | | LIC. # | RESOLUTION |
|---|---|---|---|---|---|
| 1. | MD-06-0299A | J.B. | JAMES L. ROBROCK, M.D. | 16209 | Uphold ED Dismissal. |

JB was present and spoke during the Call to Public. JB noted that Dr. Robrock had been brought up on several charges in the past. JB felt Dr. Robrock should be held accountable for his actions.

| NO. | CASE NO. | COMPLAINANT v PHYSICIAN | | LIC. # | RESOLUTION |
|---|---|---|---|---|---|
| 2. | MD-06-0710A | G.N. | MICHAEL S. WENG, M.D. | 18604 | Uphold ED Dismissal. |

GN was present and spoke during the Call to Public on behalf of his son, the patient. GN stated that he spoke with Dr. Weng prior to his son's surgery and Dr. Weng told him not to worry about a thing. GN also stated that Dr. Weng did not do any type of post operative follow up on his son. He also stated that the surgery should have been done right the first time, and there was no explanation as to why there was an extra incision made. He stated that his son should not have needed additional surgery and feels that Dr. Weng should have to pay for that additional surgery instead of their own insurance.

LN was also present and spoke during the Call to Public on behalf her son. LN stated that they would like the Board to reinvestigate this case and stated the family still did not have any explanation as to why there was an additional incision on her son's leg. Her son's leg is crooked and they can hear a noise when he tries to walk on it. She stated that her son still walks with a limp and Dr. Weng should be held accountable so that this did not happen to anyone else.

Lorraine Mackstaller, M.D. stated that she was concerned and thought that maybe this physician should come in for a Formal Interview.

Gerald Moczynski, M.D., Medical Consultant briefly summarized the case for the Board and informed them on how the surgery went. Dr. Moczynski told the Board that Dr. Weng did see the patient the next day. He stated this was a technical error. The fracture was not crooked, it was rotational and Dr. Weng was not afforded the opportunity to address the issue again. Dr.

Moczynski informed the Board that even if corrected it is not unusual to still hear some sounds, especially with weight bearing activities.

Ram R. Krishna, M.D. stated that interlocking is the way to go. Dr. Weng thought it was stable and could have inserted an interlocking screw but was not given the chance to do so.

**MOTION: Lorraine Mackstaller, M.D. moved to uphold the ED dismissal.**
**SECONDED: Patrick N. Connell, M.D.**
**VOTE: 12-yay, 0-nay, 0-abstain, 0-recuse, 0-absent.**
**MOTION PASSED**

| NO. | CASE NO. | COMPLAINANT v PHYSICIAN | | LIC. # | RESOLUTION |
|---|---|---|---|---|---|
| 3. | MD-06-0778A | D.M. | ASHWIN R. PATEL, M.D. | 30254 | Uphold ED Dismissal. |
| 4. | MD-06-0176A | E.L. | BERNADETTE J. ARNECKE, M.D. | 16897 | Uphold ED Dismissal. |

EL was present and spoke during the Call to Public. EL stated that Dr. Arnecke overly prescribed the patient, his wife, who is now deceased and has a complete lack of oversight. EL stated that a pulmonologist did inform him that this was only a matter of months before cancer would have caused her death. His key point was that Dr. Arnecke cannot possibly know all the information when signing off on death certificates. EL urged the Board to reconsider this case and discipline Dr. Arnecke.

| NO. | CASE NO. | COMPLAINANT v PHYSICIAN | | LIC. # | RESOLUTION |
|---|---|---|---|---|---|
| 5. | MD-06-0317A | C.B. | BRYAN K. MATANKY, M.D. | 22110 | Uphold ED Dismissal. |
| 6. | MD-06-0327A | P.H. | PATTI A. FLINT, M.D. | 23855 | Reject the ED Dismissal and return for further investigation. |

PH was present and spoke during Call to Public. PH stated that initially she wanted to see a woman physician, thinking a woman physician would better understand a woman's needs. She stated the main thing she wanted the Board to know is how it affected her life and to know that Dr. Flint would not be held responsible just adds insult to injury. Dr. Flint was careless during the surgery and then lied about the outcome.

Paul M. Petelin, Sr., M.D. stated that he did not see a reason why two different medical consultants reviewed this case. He stated PH's observation was that her left breast was slightly larger than the right. Dr. Petelin noted that when Dr. Flint went in to correct the problem, she erroneously removed a greater amount of tissue from the smaller breast which led to a greater asymmetry on the left side.

**MOTION: Paul M. Petelin, Sr., M.D. moved to reject the ED Dismissal and return this case for further investigation.**
**SECONDED: Patrick N. Connell, M.D.**
**VOTE: 12-yay, 0-nay, 0-abstain, 0-recuse, 0-absent.**
**MOTION PASSED**

| NO. | CASE NO. | COMPLAINANT v PHYSICIAN | | LIC. # | RESOLUTION |
|---|---|---|---|---|---|
| 7. | MD-06-0653A | D.K. | JOSEPH P. AIELLO, M.D. | 15612 | Uphold ED Dismissal. |
| 8. | MD-06-0856A | S.S. | FREDERICK J. MENICK, M.D. | 11308 | Uphold ED Dismissal. |
| 9. | MD-06-0889A | G.C. | AASHISH N. SAGAR, M.D. | 33270 | Uphold ED Dismissal. |

## OTHER BUSINESS

**MOTION: Lorraine Mackstaller, M.D. moved to accept the consent agreements in items 2-9.**
**SECONDED: Patrick N. Connell, M.D.**
**Vote: 12-yay, 0-nay, 0-abstain, 0-recuse, 0-absent.**
**MOTION PASSED.**

**MOTION: Ram R. Krishna, M.D. moved to accept the draft Findings of Fact, Conclusions of Law and Order in items 11, 13, 14, 15, 16, and 18.**
**SECONDED: Douglas D. Lee, M.D.**
**Vote: 12-yay, 0-nay, 0-abstain, 0-recuse, 0-absent.**
**MOTION PASSED.**

| NO. | CASE NO. | COMPLAINANT v PHYSICIAN | | LIC. # | RESOLUTION |
|---|---|---|---|---|---|
| 1. | MD-05-0652A | C.R. | FERNANDO CRUZADO, M.D. | 30961 | Reject the consent agreement and offer an amended consent agreement to include 20 hours CME in ethics. If the physician declines, invite him for a formal interview. |

Dona Pardo, Ph.D., R.N. stated that reading through this case, it seemed there was quite a bit of ethical issues with the physician.

Tina Geiser, Senior Investigator presented the Board with the ethical issues in the case. She stated that Dr. Cruzado provided Board Staff with a copy of the patient file, which was also received from the patient, which indicated additional entries. The additional information was not dated. Ms. Geiser told the Board that Dr. Cruzado did not come forth and tell Board Staff, it was only after Staff had confronted him that he admitted it. The altered original chart was considered misrepresenting the record.

Dr. Pardo was also concerned of the allegation that a non-licensed person was practicing in Dr. Cruzado's practice. William R. Martin, III, M.D. asked Dr. Pardo if in her experience, cases like these end up in a Letter of Reprimand or a higher level of discipline. Dr. Pardo stated that the Board considers this very serious. Dr. Martin agreed. He thought there was a purposeful attempt to mislead people in this case by the physician. Dr. Martin felt a Letter of Reprimand as an ultimate closure of this case is not appropriate.

Ram R. Krishna, M.D. did not feel this rose to the level of a Decree of Censure, it had some patient harm but not to that extent. Dr. Pardo wondered if CME in ethics would help. Lorraine Mackstaller, M.D. noted that there are CME included in the Consent Agreement, but it is not ethics. Paul M. Petelin, Sr., M.D. proposed the Board add ethical issues to the CME or have it take place of the existing CME in the Proposed Consent Agreement.

**MOTION: Ram R. Krishna, M.D. moved to reject the consent agreement and offer an amended consent agreement to include 20 hours CME in ethics. If the physician declines, invite him for a formal interview.**
**SECONDED: Patrick N. Connell, M.D.**
**ROLL CALL VOTE: Roll call vote was taken and the following Board Members were in favor of the motion: Patrick N. Connell, M.D., Dan Eckstrom, Robert P. Goldfarb, M.D., Patricia R.J. Griffen, Ram R. Krishna, M.D., Douglas D. Lee, M.D., Lorraine Mackstaller, M.D., William R. Martin, III, M.D., Dona Pardo, Ph.D., R.N., Germaine Proulx, and Amy J. Schneider, M.D. The following Board Members were against the motion: Paul M. Petelin, Sr., M.D.**
**Vote: 11-yay, 1-nay, 0-abstain, 0-recuse, 0-absent.**
**MOTION PASSED.**

| NO. | CASE NO. | COMPLAINANT v PHYSICIAN | | LIC. # | RESOLUTION |
|---|---|---|---|---|---|
| 2. | MD-05-0504C | AMB | JOSEPH R. VOLK, M.D. | 13382 | Accept proposed consent agreement for a Letter of Reprimand for failure to adequately assess a patient with profoundly low platelets and hemolytic anemia and initiate treatment. |
| 3. | MD-05-1203A | AMB | ROBERT B. PASTERZ, M.D. | 10596 | Accept proposed consent agreement for a Letter of Reprimand for altering medical records and for delay in the diagnosis and treatment of prostate cancer. |
| 4. | MD-05-1202B | AMB | CAROL L. HENRICKS, M.D. | 25445 | Accept proposed consent agreement for a Letter of Reprimand for failure to diagnose a herniated disk in a timely manner and failure to maintain adequate records. |
| 5. | MD-05-0482A | AMB | VILAS DESHPANDE, M.D. | 20706 | Accept proposed consent agreement for a Letter of Reprimand for wrong site surgery. |
| 6. | MD-06-0182B | AMB | MARK ZACHARY, M.D. | 12879 | Accept proposed consent agreement for a Letter of Reprimand for failure to diagnose and treat SS's right ankle fracture in a timely manner resulting in a non-united fracture requiring surgical intervention. |
| 7. | MD-06-0771A | AMB | MOHAMMAD S. KHERA, M.D. | 33175 | Accept proposed consent agreement for a Letter of Reprimand for action taken by another State for fraudulent billing. |
| 8. | MD-06-0438A | M.W. | SUSAN B. FLEMING, M.D. | 14840 | Accept proposed consent agreement for a Letter of Reprimand for improper prescribing, inadequate examination of the patient, prescribing in excess of findings reported, failure to recognize or deal with evidence of narcotics abuse on several occasions. One year Probation to obtain 20 hours CME for controlled substance prescribing. |
| 9. | MD-05-1015A | V.M. | MELANIE K. KOHOUT, M.D. | 23105 | Accept proposed consent agreement for Revocation. |
| 10. | MD-07-L021A | AMB | RICKY OCHOA, M.D. | 72488 | Accept proposed consent agreement for Probationary License with MAP terms. |

Ms. Cassetta informed the Board members that they had been provided with a Non-Disciplinary Consent Agreement for Ricky Ochoa, M.D., but the actual Consent Agreement he executed is disciplinary.

Lorraine Brown, Senior Investigator informed the Board that Dr. Ochoa had completed his residency since 2004.

**MOTION: Douglas D. Lee, M.D. moved to accept the Proposed Consent Agreement.**

**SECONDED: Ram R. Krishna, M.D.**
**ROLL CALL VOTE: Roll call vote was taken and the following Board Members were in favor of the motion: Patrick N. Connell, M.D., Dan Eckstrom, Robert P. Goldfarb, M.D., Patricia R.J. Griffen, Ram R. Krishna, M.D., Douglas D. Lee, M.D., Lorraine Mackstaller, M.D., William R. Martin, III, M.D., Dona Pardo, Ph.D., R.N., Paul M. Petelin, Sr., M.D., Germaine Proulx, and Amy J. Schneider, M.D.**
**MOTION PASSED.**

| NO. | CASE NO. | COMPLAINANT v PHYSICIAN | | LIC. # | RESOLUTION |
|---|---|---|---|---|---|
| 11. | MD-05-0341A<br>MD-05-0434A<br>MD-05-0701A<br>MD-05-0702A<br>MD-05-0703A<br>MD-05-0704A<br>MD-05-0705A<br>MD-05-1062A | S.O.<br>J.S.<br>L.K.<br>B.L.<br>B.G.<br>V.R.<br>J.K.<br>M.K. | CYNTHIA J. MODNY, M.D. | 22577 | Accept Draft Findings of Fact, Conclusions of Law and Order for failure to maintain adequate medical records, for charging a fee for services not rendered, and for ongoing behavior issues that adversely affect patient care. One Year Probation to obtain a treating psychiatrist. |

JS, patient of Dr. Modny, was present and spoke during the Call to Public. JS also read a letter on behalf of another patient of Dr. Modny's. The letter read that the patient was always treated fairly during their care with Dr. Modny. The letter noted Dr. Modny's allergy and stated this seemed like a small request for the amount of care she delivered to her patients. JS stated that he was originally referred to Dr. Modny by his previous dermatologist for a skin problem his physician misdiagnosed. JS found Dr. Modny to be very professional and thorough. He felt that she was a dermatologist he could always go back to and depend on.

MG was present and spoke during the Call to Public on behalf of one of Dr. Modny's patients, BCM. BCM was Dr. Modny's patient from 1998 until 2006. The complaint that BCM presented to Dr. Modny with disintegrated within days after being treated by her.

Cynthia J. Modny, M.D. was also present and spoke during the Call to Public. Dr. Modny stated that she had been licensed for 36 years. She attempted to continue her practice but the demand of her illness required certain things from her patients. Dr. Modny stated that there was never any issue regarding the quality of care she delivered to her patients. She requested recognition of her illness and that the Board remove any psychiatric evaluations from her Order.

| NO. | CASE NO. | COMPLAINANT v PHYSICIAN | | LIC. # | RESOLUTION |
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| 12. | MD-05-0861A | AMB | MITCHELL R. HALTER, M.D. | 29626 | Accept Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand for inadequate management of eight patients. 2 year Probation restricting him from implanting pain management related devices until the doctor has obtained further training in the techniques of implantation and the treatment of complications of the implanted devices acceptable to the Board, specifically, 15 hours Category One CME in implantation of pain management devices and management of complications. He may not apply for modification of the restriction for at least six months. |

Lorraine Mackstaller, M.D. recused herself from this case.

The Board asked for Staff to clarify the issue of CME that Dr. Halter's attorney, Dan Jantsch, had brought up in a letter submitted to the Board prior to the meeting. Christine Cassetta, Board Legal Counsel informed the Board that she had spoken with Mr. Jantsch and clarified that the Board's Model Orders always require Category I CME. Sue Dana, Compliance Officer addressed the Board and stated that she could not find 20 hours for the CME requested. She informed the Board that Dr. Halter attended a course ran by Medtronics and attended 14 and one half hours.

The Board thought it was understood that if the hours were close to the requested hours, it did not need to come back to the Board for approval. Christine Cassetta, Board Legal Counsel told the Board there was some confusion that arose due to the Category One CME and the PRA.

**MOTION: Douglas D. Lee, M.D. moved to accept the Draft Findings of Fact, Conclusions of Law and Order as modified to read a minimum of 15 hours, Category One CME in implantation of pain management devices and management of complications.**
**SECONDED: Patrick N. Connell, M.D.**
**Vote: 11-yay, 0-nay, 0-abstain, 1-recuse, 0-absent.**
**MOTION PASSED.**

| NO. | CASE NO. | COMPLAINANT v PHYSICIAN | | LIC. # | RESOLUTION |
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| 13. | MD-05-0622A | AMB | MICHAEL S. BISCOE, M.D. | 20915 | Accept Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand for failure to recognize and treat meningococcemia in a timely manner, failure to repeat physical examinations during the time the patient was in |

| NO. | CASE NO. | COMPLAINANT v PHYSICIAN | | LIC. # | RESOLUTION |
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| | | | | | the emergency department and for inadequate medical records. |
| 14. | MD-06-0018A | AMB | DONALD K. HOPEWELL, M.D. | 33348 | Accept Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand for knowingly making a false statement to the Board on the license application. |
| 15. | MD-06-0292B | AMB | ERICK R. MARTINEZ, M.D. | 20874 | Accept Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand for failing to inform the patient that the tubal ligation had not been performed. |
| 16. | MD-06-0318A | AMB | LARRY P. PUTNAM, M.D. | 9233 | Accept Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand for habitual intemperance, inappropriate prescribing and for failing to maintain adequate records on a patient. Five year Probation with MAP terms including a treating psychiatrist (He shall receive credit for the time he was under the interim order for MAP). |
| 17. | MD-06-0055A | AMB | DIEGO G. CARDENAS, M.D. | 19750 | Accept Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand for delay in diagnosis and treatment of a pregnant patient with bactiuria. |

Ms. Dee Dee Holden was present and spoke during the Call to Public on behalf of Dr. Cardenas. She stated that during the last meeting the Board found a Letter of Reprimand was appropriate in this case. Ms. Holden believed that paragraph 11 is inconsistent with the Board's decision stating RL's diagnosis was delayed and ultimately led to the demise of the patient. She believed it would be more appropriate if the Order stated he did not diagnose and it did or may have led to the patient's demise.

The Board noted that Ms. Holden's objection in writing was somewhat different form her statement given at the Call to Public. Ms. Cassetta informed the Board that she drafted the standard of care, deviation, and harm/potential harm exactly as articulated by Dr. Connell during the interview. Ms. Cassetta noted Ms. Holden's objection to the Board citing (q) ignores the "is" in the phrase "is or may be harmful." The Board declined to change the statutory citation but voted to add a reference to the text Dr. Connell referred to in the formal interview.

**MOTION: Patrick N. Connell, M.D. moved to accept the Findings of Fact, Conclusions of Law and Order as modified.**
**SECONDED: Paul M. Petelin, Sr., M.D.**
**Vote: 12-yay, 0-nay, 0-abstain, 0-recuse, 0-absent.**
**MOTION PASSED.**

| NO. | CASE NO. | COMPLAINANT v PHYSICIAN | | LIC. # | RESOLUTION |
|---|---|---|---|---|---|
| 18. | MD-06-0277A | C.P. | JOE T. HAYASHI, M.D. | 12865 | Draft Findings of Fact, Conclusions of Law and Order |
| 19. | MD-06-0293A | M.S. | RAMACHANDRA N. RAO, M.D. | 25615 | Draft Findings of Fact, Conclusions of Law and Order |

Gordon Lewis from Jones, Skelton and Hochuli was present and spoke during the Call to Public on behalf of Dr. Rao. Mr. Lewis referred the Board to the proposed changes he had submitted to the Board prior to the meeting. He stated that Dr. Rao felt very strong about changing "progressed" in Finding of Fact 14 to "happened" because he believes the hyponatremia happened after leaving his office, and she was not hyponatremic while she was there. Dr. Rao also felt strongly that if he would have known, he would not have let her leave his office until it was addressed.

Christine Cassetta, Board Legal Counsel informed the Board that Mr. Lewis had requested nine different changes to the Order, eight of which were only minor and she had made those changes. Ms. Cassetta noted she recalled the Board was specific that the issue was that the patient's hyponatremia progressed after she left Dr. Rao's office and she declined to make the final requested change because it would change the entire meaning of Finding of Fact 14. Ms. Cassetta noted she consulted with Dr. Nanney for his medical opinion and he agreed it would medically change the meaning of the paragraph and state the hyponatremia happened after Dr. Rao treated the patient.

Mark Nanney,M.D., Chief Medical Consultant briefly summarized the case to inform the Board whether or not the patient had it while there rather than after leaving Dr. Rao's office.

Lorraine Mackstaller, M.D. did not believe that a sodium of 104 happened in 48 hours.

**MOTION: Lorraine Mackstaller, M.D. moved to accept the Findings of Fact, Conclusions of Law and Order with the proposed changes, except for the proposed change to Paragraph 14.**
**SECONDED: Patrick N. Connell, M.D.**
**Vote: 12-yay, 0-nay, 0-abstain, 0-recuse, 0-absent.**
**MOTION PASSED.**

| NO. | CASE NO. | COMPLAINANT v PHYSICIAN | | LIC. # | RESOLUTION |
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| NO. | CASE NO. | COMPLAINANT v PHYSICIAN | | LIC. # | RESOLUTION |
|---|---|---|---|---|---|
| 20. | MD-06-0079A | E.A. | MICHAEL E. GRANBERRY, M.D. | 28676 | Accept Draft Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand for failing to take a culture and failing to personally follow up on a post-operative complication. |

Ms. Cassetta noted the Board's motion for unprofessional conduct during the interview was that Dr. Granberry deviated from t he standard of care by failing take the culture. However, when making the motion for discipline the Board cited Dr. Granberry for failing to take the culture and for failure to follow up with the patient. Ms. Cassetta requested the Board clarify whether Dr. Granberry deviated from the standard of care in both respects.

Patrick N. Connell, M.D. stated that Dr. Granberry deviated by failing to take the culture and by failing to follow up with the patient.

**MOTION: Patrick N. Connell, M.D. moved to accept the Draft Findings of Fact, Conclusions of Law as amended and to amend the Board's previous motion on the standard of care to include the requirement that Dr. Granberry personally follow-up with the patient's post-operative complication and that he deviated by abdicating this care to an optometrist.**
**SECONDED: Douglas D. Lee, M.D.**
**Vote: 12-yay, 0-nay, 0-abstain, 0-recuse, 0-absent.**
**Motion passed.**

| NO. | CASE NO. | COMPLAINANT v PHYSICIAN | | LIC. # | RESOLUTION |
|---|---|---|---|---|---|
| 21. | MD-06-0505A | AMB | SURESH B. KATAKKAR, M.D. | 11471 | Dismiss |

Mark Nanney, M.D., Chief Medical Consultant felt this was an important case and happened to agree with the OMC in recommending dismissal.

Ram R. Krishna, M.D. wondered if chemotherapy would depress the patient's white cells and would it cause Leukemia later. OMC stated the treatment received was appropriate.

**MOTION: Ram R. Krishna, M.D. moved to dismiss this case.**
**SECONDED: Patrick N. Connell, M.D.**
**Vote: 12-yay, 0-nay, 0-abstain, 0-recuse, 0-absent.**
**Motion passed.**

| NO. | CASE NO. | COMPLAINANT v PHYSICIAN | | LIC. # | RESOLUTION |
|---|---|---|---|---|---|
| 22. | MD-06-0439A<br>MD-06-0849A<br>MD-04-1163A | AMB | WILLIAM V. GAUL, M.D. | 13119 | Revocation |

Kathleen Muller, Physician Health Program Manager briefly summarized the case for the Board. The Board noted that Dr. Gaul violated his Interim Consent Agreement.

**MOTION: Douglas D. Lee, M.D. moved to find Dr. Gaul in violation of his Interim Consent Agreement, lift the stay and Revoke Dr. Gaul's license.**
**SECONDED: Patrick N. Connell, M.D.**
**ROLL CALL VOTE: Roll call vote was taken and the following Board Members were in favor of the motion: Patrick N. Connell, M.D., Dan Eckstrom, Robert P. Goldfarb, M.D., Patricia R.J. Griffen, Ram R. Krishna, M.D., Douglas D. Lee, M.D., Lorraine Mackstaller, M.D., William R. Martin, III, M.D., Dona Pardo, Ph.D., R.N., Paul M. Petelin, Sr., M.D., Germaine Proulx, and Amy J. Schneider, M.D.**
**Vote: 12-yay, 0-nay, 0-abstain, 0-recuse, 0-absent.**
**MOTION PASSED.**

| NO. | CASE NO. | COMPLAINANT v PHYSICIAN | | LIC. # | RESOLUTION |
|---|---|---|---|---|---|
| 23. | MD-06-0669A | AMB | WILLIAM E. MORA, M.D. | 13088 | Deny appeal of ED Referral to Formal Hearing |

Ram R. Krishna, M.D. asked if there were anything more the Board could do with this case. He felt this case should be forwarding to the Office of Administrative Hearings.

**MOTION: Ram R. Krishna, M.D. moved to deny the appeal and forward to Formal Hearing.**
**SECONDED: Patrick N. Connell, M.D.**
**Vote: 12-yay, 0-nay, 0-abstain, 0-recuse, 0-absent.**
**MOTION PASSED.**

| NO. | CASE NO. | COMPLAINANT v PHYSICIAN | | LIC. # | RESOLUTION |
|---|---|---|---|---|---|
| 24. | MD-07-0125A | AMB | CYNTHIA J MODNY, M.D. | 22577 | Accept proposed consent agreement for surrender of active license (Non-Disciplinary). |
| 25. | MD-05-0553A | AMB | ALBERT F. OLIVIER, M.D. | 9954 | Accept proposed consent agreement for a Letter of Reprimand for performing surgery without adequate |

| NO. | CASE NO. | COMPLAINANT v PHYSICIAN | | LIC. # | RESOLUTION |
|---|---|---|---|---|---|
| | | | | | indications and lack of informed consent. |

**MOTION: Lorraine Mackstaller, M.D. moved to accept Consent Agreements on Other Business items 24 and 25.**
**SECONDED: Ram R. Krishna, M.D.**
**ROLL CALL VOTE: Roll call vote was taken and the following Board Members were in favor of the motion: Patrick N. Connell, M.D., Dan Eckstrom, Robert P. Goldfarb, M.D., Patricia R.J. Griffen, Ram R. Krishna, M.D., Douglas D. Lee, M.D., Lorraine Mackstaller, M.D., William R. Martin, III, M.D., Dona Pardo, Ph.D., R.N., Paul M. Petelin, Sr., M.D., Germaine Proulx, and Amy J. Schneider, M.D.**
**Vote: 12-yay, 0-nay, 0-abstain, 0-recuse, 0-absent.**
**MOTION PASSED.**

## OTHER BUSINESS

| NO. | CASE NO. | COMPLAINANT v PHYSICIAN | | LIC. # | RESOLUTION |
|---|---|---|---|---|---|
| 1. | MD-06-0209A | UPH | JERRY L. BANGERT, M.D. | 11270 | Upheld ED Dismissal |
| 2. | MD-06-0212A | UPH | NORMAN LEVINE, M.D. | 10538 | Dismiss |
| 3. | MD-06-0401A | UPH | ROBYN E. F. GLAESSER, M.D. | 27480 | Dismiss |
| 4. | MD-06-0633A | AMB | RONALD G. WHEELAND, M.D. | 12339 | Dismiss |

Lorraine Mackstaller, M.D. recused herself from Other Business #1-4.
**MOTION: Patrick N. Connell, M.D. moved to uphold the ED Dismissal for Other Business #1 and dismiss #2-4.**
**SECONDED: Ram R. Krishna, M.D.**
**Vote: 12-yay, 0-nay, 0-abstain, 0-recuse, 0-absent.**
**MOTIONPASSED.**

## Wednesday, April 11, 2007

### Call to Order
The meeting was called to order at 9:30 am

### Roll Call
The following Board Members were present: Patrick N. Connell, M.D., Dan Eckstrom, Robert P. Goldfarb, M.D., Patricia R.J. Griffen, Ram R. Krishna, M.D., Douglas D. Lee, M.D., Lorraine Mackstaller, M.D., William R. Martin, III, M.D., Dona Pardo, Ph.D., R.N., Paul M. Petelin, Sr., M.D., Germaine Proulx, and Amy J. Schneider, M.D.

### Call to Public
The statements issued during Call to Public appear beneath the case referenced.

## FORMAL INTERVIEWS

| NO. | CASE NO. | COMPLAINANT v PHYSICIAN | | LIC. # | RESOLUTION |
|---|---|---|---|---|---|
| 1. | MD-06-0047A | J.P. | DARRELL J. JESSOP, M.D. | 23441 | Draft Findings of Fact, Conclusions of Law and Order for Letter of Reprimand for improper methadone dosing and improper management of accidental opiate overdose. One year Probation for 10 hours CME in pain management, including diagnosis and treatment, in addition to the CME required for license renewal, within six months. Following completion of the CME, Board Staff shall conduct random chart reviews to ensure the CME is applied. |

Darrell J. Jessop, M.D. was present without counsel.

Dr. Jessop gave an opening statement prior to receiving questions from the Board. Dr. Jessop stated it is understood that physicians still make mistakes. Primary care physicians cannot and should not be held to the same community standard of care as specialists. Dr. Jessop stated that many primary care physicians do not obtain adequate histories of their patients and do not keep records of what pain medications are prescribed.

Carol Peairs, M.D., Medical Consultant summarized the case for the Board. Staff noted aggravating factors of two prior Advisory Letters for the same.

Douglas D. Lee, M.D. let the questioning and asked Dr. Jessop what his specialty is and what medical background he has. Dr. Lee asked Dr. Jessop if he had any additional training in pain management and Dr. Jessop stated he did not. Dr. Jessop stated that about 10 percent of his patients in his practice are the same as the patient in question. Dr. Lee asked if Dr. Jessop was aware

of methadone side effects in 2002-2003. Dr. Jessop stated he was aware of prolonged half life, but was not aware fully of the impact of opioids being prescribed to this patient. He stated he was not very familiar with methadone in his practice back then. Dr. Jessop stated that now looking back, he feels his prescribing was significantly excessive. Even with appropriate methadone, it can still cause overdose.

Dr. Jessop stated there is nothing stating he is a specialist in pain management. He stated that further training in pain management might have been a good idea, but everyone who practices medicine deals with pain patients and they could be very difficult. He believed physicians should be held to the same as a specialist but unfortunately most family care physicians do not have that type of training. Lorraine Mackstaller, M.D. asked Dr. Jessop if he ever thought about the ideology of this patient's pain. Dr. Jessop stated yes and that he was seen by another physician in the community. Dr. Jessop noted that the patient went to a pain management facility and opted not to have any IV treatment performed. Dr. Jessop informed the Board that he is no longer seeing the patient.

The Board noted that Dr. Jessop did not develop a diagnosis based on his findings, but rather on the patient's subjective complaints. Dr. Jessop stated that this patient was also seen by Mitchell Halter, M.D. and felt that if he is guilty perhaps all the physicians involved should be held accountable, too.

When Dr. Jessop first consulted with the patient, he started him on Oxycontin. Dr. Goldfarb felt this was a huge leap without any positive findings. Dr. Goldfarb stated he could not figure out how Dr. Jessop works with patients other than prescribing. Dr. Jessop stated that absence of physical findings does not rule out pain. Dr. Goldfarb verified with Carol Peairs, M.D., Medical Consultant when prescribing to a patient who complains of pain, but everything looks normal, that one should not escalate the prescriptions.

William R. Martin, III, M.D. noted that in Dr. Jessop's opening statement, he stated it was difficult to obtain training in pain management. Dr. Jessop stated that in terms of CME, there are courses and he has taken them. However, each patient is different and is approached differently. There are some guidelines in terms of the approach but it is still largely individualized. In a primary care setting it can be even more difficult. Dr. Jessop stated he is aware of the Board's guidelines for pain management; only thing he did not see is that he would need to have objective evidence for prescribing.

Carol Peairs, M.D., Medical Consultant informed the Board that, at that time of Dr. Jessop's treatment in this case, that specific language was not in the guidelines.

**MOTION: Douglas D. Lee, M.D. moved for a finding of Unprofessional Conduct in violation of A.R.S. § 32-1401(27)(q) – Any conduct that is or might be harmful or dangerous to the health of the patient or the public and A.R.S. § 32-1401(27)(ll) – Conduct that the board determines is gross negligence, repeated negligence or negligence resulting in harm to or the death of a patient.**
**SECONDED: Patrick N. Connell, M.D.**
**Vote: 12-yay, 0-nay, 0-abstain, 0-recuse, 0-absent.**
**MOTION PASSED.**

**MOTION: Douglas D. Lee, M.D. moved to Draft Findings of Fact, Conclusions of Law and Order for Letter of Reprimand for improper methadone dosing and improper management of accidental opiate overdose. One year Probation for 10 hours CME in pain management, including diagnosis and treatment, in addition to the CME required for license renewal, within six months. Following completion of the CME, Board Staff shall conduct random chart reviews to ensure the CME is applied.**
**SECONDED: Patrick N. Connell, M.D.**

Paul M. Petelin, Sr., M.D. was in favor of the motion and stated he has a bigger problem with the failure to adequately manage what appeared to be an overdose. Patrick N.Connell, M.D. stated that in a sense, the patient and the physician were lucky that the outcome was not considerably worse. Dr. Connell felt this was a very significant oversight that could have resulted in the death of the patient. Dona Pardo, Ph.D., R.N. was concerned if the additional CME should be specific for methadone. Lorraine Mackstaller, M.D. stated she was not too sure if the CME would include a reasonable diagnosis prior to initiation of narcotics, but stated she would envision it would be from diagnosis to treatment.

Ram R. Krishna, M.D. noted that Dr. Jessop might still be practicing pain management and stated that Dr. Jessop should have a certain amount of time fore when he needs to have the CME done. Dr. Krishna stated that a whole year for the CME was inappropriate.

Christine Cassetta, Board Legal Counsel stated the Board can leave the wording as is and add to it that Dr. Jessop needs to complete the CME in 60 days and have chart reviews done in the six moth period to see that he is applying what he learned.

**Roll Call Vote: Roll Call cote was taken and the following Board Members voted in favor of the Motion: Patrick N. Connell, M.D., Dan Eckstrom, Robert P. Goldfarb, M.D., Patricia R.J. Griffen, Ram R. Krishna, M.D., Douglas D. Lee, M.D., Lorraine Mackstaller, M.D., William R. Martin, III, M.D., Dona Pardo, Ph.D., R.N., Paul M. Petelin, Sr., M.D., Germaine Proulx, and Amy J. Schneider, M.D.**
**Vote: 12-yay, 0-nay, 0-abstain, 0-recuse, 0-absent.**
**MOTION PASSED.**

| NO. | CASE NO. | COMPLAINANT v PHYSICIAN | | LIC. # | RESOLUTION |
|---|---|---|---|---|---|
| 2. | MD-05-0910A | AMB | MONIQUE B. ARIZE, M.D. | 18147 | Advisory Letter for failure to correctly diagnose a malignancy. The matter does not rise to the level of discipline. |

Monique B. Arize, M.D. was present without counsel.

Patrick N. Connell, M.D. stated he knew Dr. Arize from previous practice, but did not feel it would affect his ability to adjudicate this case. William R. Martin, III, M.D. stated he also knew Dr. Arize, but did not feel it would affect his ability to adjudicate this case.

Kelly Sems, M.D., Internal Medical Consultant summarized the case for the Board. Staff found that Dr. Arize failed to correctly diagnose a malignancy.

Dr. Arize gave an opening statement prior to receiving questions from Board Members. She stated that some of the facts are incorrect. She stated that when her colleague, Dr. Allen saw the specimen that night, he was not given any information with regards to the patient's history. Dr. Allen made the diagnosis from what they saw, not from any history. She stated that what they saw was a papillary tumor surrounded by lymphocytes. She specified that she did not know if the tumor was entirely excised, if she would have known, she would have ordered additional slides.

Ram R. Krishna, M.D. led the questioning and asked Dr. Arize if she found fault with the physician who did the frozen section for not diagnosing the tumor. Dr. Arize stated that if she had seen it at the beginning, she may have thought it was malignant rather than benign, but cannot answer that since she was not there. Dr. Arize stated she went along with Dr. Allen's diagnosis and went in that direction. The diagnosis was corrected and Dr. Arize agreed that she did miss the diagnosis. The prognosis would have changed if they would have known at that time. The survival rate is impossible to tell, but a patient should have a normal life span with the right treatment delivered. She stated that to rectify what had happened, they now consult with specialists and review all information.

Dr. Arize stated that looking at the slides now she is shocked and cannot believe how she missed it at the time. She cannot explain her thought process other than she followed her colleague, Dr. Allen. She did not think Dr. Allen consulted with a surgeon, she stated the procedure went more routinely rather than treated as an emergent case.

Robert P. Goldfarb, M.D. asked if it were standard of care for two physicians to review this case. Dr. Arize stated that Dr. Allen looked at the frozen section and she looked at the final slides. William R. Martin, III, M.D. asked if every specimen that is submitted from the operating room receive a fresh frozen reading. He asked why her colleague was involved. Dr. Arize stated that usually when the specimen is received, a surgeon will review if it is benign or malignant.

In Dr. Arize's closing statement, she stated that we all make mistakes. Unfortunately her name was on the report, not that she excused herself, but they needed to know that Cornell University also missed the diagnosis and they all made a mistake. Dr. Arize wished the patient the best and apologized.

Ram R. Krishna, M.D. stated that he appreciated Dr. Arize's honesty, but there was patient harm done due to the delay in treatment. He felt it unfortunate that they would have to come up with some findings but felt there were various findings of unprofessional conduct.

**MOTION: Ram R. Krishna, M.D. moved for a finding of Unprofessional Conduct in violation of A.R.S. § 32-1401(27)(q) – Any conduct that is or might be harmful or dangerous to the health of the patient or the public and A.R.S. § 32-1401(27)(ll) – Conduct that the board determines is gross negligence, repeated negligence or negligence resulting in harm to or the death of a patient.**
**SECONDED: Patrick N. Connell, M.D.**
**12-yay, 0-nay, 0-abstain, 0-recuse, 0-absent.**
**MOTION PASSED.**

**MOTION: Ram R. Krishna, M.D. moved to Draft Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand for failure to correctly diagnose a malignancy.**
**SECONDED: Paul M. Petelin, Sr., M.D.**

William R. Martin, III, M.D. asked Dr. Krishna if he felt it was mitigating that similar diagnosis were missed and that this was a rare tumor to begin with. Dr. Krishna felt the motion stands because there was patient harm.

Robert P. Goldfarb, M.D. stated that he assessed the case a bit differently. If one is a radiologist or a pathologist, one cannot be right every single time one reviews an x-ray or a past slide. He stated this was misdiagnosed by other people that were named earlier in the interview. Dr. Goldfarb noted that Dr. Arize has no prior Board history and he is in favor of an Advisory Letter.

Patrick N. Connell, M.D. agreed with Dr. Goldfarb and stated he would support and Advisory Letter.

Paul M. Petelin, Sr., M.D. disagreed with an Advisory Letter and stated that Dr. Arize was caught up a bit and went down the wrong path. Unfortunately when physicians do make mistakes and a patient suffers, they have to pay the consequences. Dr. Petelin was in support of the Letter of Reprimand.

Lorraine Mackstaller, M.D. stated that physicians need to make their own diagnoses, but agreed with Dr. Goldfarb. She stated that more than one pathologist failed to make the diagnosis.

Robert P. Goldfarb, M.D. stated that one cannot be right every time when practicing medicine. Physicians must show that they have the knowledge and the background that they are aware.

**ROLL CALL VOTE: Roll call vote was taken and the following Board Members were in favor of the motion: Ram R. Krishna, M.D. and Paul M. Petelin, Sr., M.D. The following Board Members were against the motion: Patrick N. Connell, M.D., Dan Eckstrom, Robert P. Goldfarb, M.D., Patricia R.J. Griffen, Douglas D. Lee, M.D., Lorraine Mackstaller, M.D., William R. Martin, III, M.D., Dona Pardo, Ph.D., R.N., Germaine Proulx, and Amy J. Schneider, M.D.**
**2-yays, 10-nays, 0-abstain, 0-recuse, 0-absent.**
**MOTION FAILED.**

**MOTION: Lorraine Mackstaller, M.D. moved to issue the physician an Advisory Letter for failure to correctly diagnose a malignancy. The matter does not rise to the level of discipline.**
**SECONDED: Patrick N. Connell, M.D.**
**ROLL CALL VOTE: Roll call vote was taken and the following Board Members were in support of the motion: Patrick N. Connell, M.D., Dan Eckstrom, Robert P. Goldfarb, M.D., Patricia R.J. Griffen, Douglas D. Lee, M.D., Lorraine Mackstaller, M.D., William R. Martin, III, M.D., Dona Pardo, Ph.D., R.N., Germaine Proulx, and Amy J. Schneider, M.D. The following Board Members were against the motion: Ram R. Krishna, M.D. and Paul M. Petelin,**
**10-yays, 2-nays, 0-abstain, 0-recuse, 0-absent.**
**MOTION PASSED.**

| NO. | CASE NO. | COMPLAINANT v PHYSICIAN | | LIC. # | RESOLUTION |
|---|---|---|---|---|---|
| 3. | MD-06-0451A | AMB | A. ANTONIO TORAYA , M.D. | 5563 | Advisory Letter for a technical violation. |

A. Antonio Toraya, M.D. was present with counsel, Andrew Rosenzweig from the firm Olson, Jantsch and Bakker.

Paul M. Petelin, Sr., M.D. recused himself from this case.

William R. Martin, III, M.D. stated that he knew Dr. Toraya, but did not feel it would affect his ability to adjudicate this case. Patrick N. Connell, M.D. also stated that he knew Dr. Toraya, but did not feel it would affect his ability to adjudicate this case.

William Wolf, M.D., Medical Consultant summarized the case for the Board. Staff found Dr. Toraya failed to make the diagnosis of a postoperative perforated duodenal ulcer.

Dr. Toraya gave an opening statement prior to receiving questions from Board Members. He stated he was sorry for the death of the patient. In review of the chart and his lack of actions, Dr. Toraya felt he did not do anything that would have led to the patient's demise. He stated he was always available to the patient.

Douglas D. Lee, M.D. led the questioning and began by briefly going over Dr. Toraya's medical training. Dr. Lee asked if Dr. Hecht was part of Dr. Toraya's call group in 2004. Dr. Toraya was not sure, but remembered Dr. Hecht asked him for a favor when he was going on vacation. He stated that this was a patient that was already part of their call group. Dr. Lee asked if it is documented in the chart when a patient is transferred to another physician within the call group. Dr. Toraya stated it is sometimes. He stated in his deposition that once you assume care of a patient, you are one hundred percent responsible for that patient until the provider comes back. Dr. Lee noted that in the patient's medical record, it stated that she was okay for discharge and Dr. Toraya made the same comments in other subsequent notes. Dr. Toraya stated that it is normal for the nursing staff to call the physicians late in the evening to inform them of gas pain. He stated it was not unusual. Dr. Toraya stated he was aware of the type of complaints the patient's pain. Dr. Lee stated that it seemed if he were aware of the extensive problems of that the patient was having the night before, prudence would demand him do some sort of more extensive examination. Dr. Toraya thought the patient was constipated and that she was having gas pain.

Lorraine Mackstaller, M.D. asked Dr. Toraya if the nurse he spoke with the next morning was the same who had called him the night in question. Dr. Toraya stated he was not sure but he was aware of the patient's shoulder pain. Dr. Toraya felt the nurses notes were very clear that she refused to take any pain medication even though she was in pain.

During his closing statements, Mr. Rosenzweig stated that it is very easy to go back and know what the outcome was. Physicians have to make judgments on what they see at the time. This was not a black and white diagnosis by Dr. Toraya. He stated that if you look at this case prospectively, Dr. Toraya's judgment was reasonable and that is what he is required to do.

**MOTION: Douglas D. Lee, M.D. moved for a finding of Unprofessional Conduct in violation of A.R.S. § 32-1401(27)(q) – Any conduct that is or might be harmful or dangerous to the health of the patient or the public.**
**SECONDED: Lorraine Mackstaller, M.D.**
**Vote: 12-yay, 0-nay, 0-abstain, 0-recuse, 0-absent.**
**MOTION PASSED.**

Douglas D. Lee, M.D. stated that the sequence of events that occurred seemed quite perplexing. The nursing notes were fairly clear. He stated that the Board can only go by what is in the chart. He felt it disturbing the amount of information in the chart seemed to decrease day by day. Dr. Lee noted that in this complicated abdominal surgical situation, it is sometimes difficult to sort out normal postoperative pain from new abdominal complications. Dr. Lee also noted that the standard of care does not require a physician to be correct one hundred percent of the time as long as the judgment exercised was reasonable.
**MOTION: Douglas D. Lee, M.D. moved to issue the physician an Advisory Letter for a technical violation.**
**SECONDED: Ram R. Krishna, M.D.**

Dona Pardo, Ph.D., R.N. spoke in support of the motion. She was concerned that the physician claimed to receive a call, but there was no notation in the chart.

Lorraine Mackstaller, M.D. spoke in support of the motion. Dr. Mackstaller noted that Dr. Toraya examined the patient while she was sleeping. While examining her, she made no complaints so the physician assumed there were none. She felt the record had poor documentation.

**ROLL CALL VOTE: Roll call vote was taken and the following Board members were in favor of the motion: Patrick N. Connell, M.D., Dan Eckstrom, Robert P. Goldfarb, M.D., Patricia R.J. Griffen, Ram R. Krishna, M.D., Douglas D. Lee, M.D., Lorraine Mackstaller, M.D., William R. Martin, III, M.D., Dona Pardo, Ph.D., R.N., Paul M. Petelin, Sr., M.D., Germaine Proulx, Amy J. Schneider, M.D.**
**MOTION PASSED.**

| NO. | CASE NO. | COMPLAINANT v PHYSICIAN | | LIC. # | RESOLUTION |
|---|---|---|---|---|---|
| 4. | MD-05-0923A | E.G. | ROBERT C. TEAGUE, M.D. | 3925 | Draft Findings of Fact, Conclusions of Law and Order for Letter of Reprimand for failing to maintain adequate medical records, and for failure to furnish information to the Board. |

Dr. Teague was present without counsel.

Paul M. Petelin, Sr., M.D. stated he knew Dr. Teague, but did not feel it would affect his ability to adjudicate this case.

Roderic Huber, M.D., Medical Consultant summarized the case for the Board. Staff found Dr. Teague was inadequate with his documentation. Tina Geiser, Senior Investigator also addressed the Board informing them that Dr. Teague failed to cooperate with the investigation. Dr. Teague failed to respond to the Board in a timely manner. Dr. Teague indicated that he did receive the initial investigation notice letter but stated that he misplaced it.

Dr. Teague gave an opening statement to the Board prior to receiving questions. He stated that on the day in question, the usual vital signs are there. He was not sure why Board Staff could not read his notes. Dr. Teague stated that thought the patient might have been angry that Dr. Teague was being blamed for misdiagnosis but did not believe that was the actual reason for the patient to request his medical record. In regards to the records being illegible, he stated he fouled up, there was nothing more for him to say.

William R. Martin, III, M.D. led the questioning and began by asking Dr. Teague for clarification. In one of his responses, Dr. Teague had some thoughts about what the purpose of the medical record was. Dr. Martin asked Dr. Teague what his understanding of the medical record was. Dr. Teague stated it was to put down information for diagnostic and care purposes. It is standard of care to have documentation so that another treating physician would be able to understand what the treatment plan was. Dr. Martin noted that Dr. Teague's notes did not reflect the patient as being diabetic. Dr. Teague stated that he did not send the complete medical record to Board Staff upon their request. The Board did not know how to proceed and wondered if they should go into executive session in order to receive legal guidance. Dr. Martin stated that information that was missing seemed to

be pertinent to this case, but then decided this matter should be closed since Dr. Teague had been cited on all statutes and just admitted that he did not furnish the Board with the whole medical file.

Dr. Teague informed the Board that his practice currently consists of strictly office work, no hospital work.

Ram R. Krishna, M.D. asked if Dr. Teague's new group expected the same kind of record keeping as he kept before. The new office has the patient fill out part of the record, which is the history part, and that becomes part of the medical record. Dr. Teague informed the Board that the new practice has a very different type of system and he has no problem with it. Dr. Teague stated that he is very content where he is and thinks that their system might even be better for him.

**MOTION: William R. Martin, III, M.D. moved for a finding of Unprofessional Conduct in violation of A.R.S. § 32-1401(27)(e) – Failure to maintain adequate medical records; and A.R.S. § 32-1401(27)(dd) – Failing to furnish information in a timely manner to the board or the board's investigatiors or representatives if legally requested by the board.**
**SECONDED: Ram R. Krishna, M.D.**
**Vote: 12-yay, 0-nay, 0-abstain, 0-recuse, 0-absent.**
**MOTION PASSED.**

**MOTION: Dona Pardo, Ph.D., R.N. moved to go into executive session.**
**SECONDED: William R. Martin, III, M.D.**
**Vote: 12-yay, 0-nay, 0-abstain, 0-recuse.**
**MOTION PASSED.**

The Board went into Executive Session for legal advice at 12:48 p.m.
The Board returned to Open Session at 12:56 p.m.
No deliberations or discussions were made during Executive Session.

**MOTION: William R. Martin, III, M.D. moved to Draft Findings of Fact, Conclusions of Law and Order for Letter of Reprimand for failing to maintain adequate medical records, and for failure to furnish information to the Board.**
**SECONDED: Patrick N. Connell, M.D.**
**ROLL CALL VOTE: Roll call vote was taken and the following Board Members were in favor of the motion: Patrick N. Connell, M.D., Dan Eckstrom, Robert P. Goldfarb, M.D., Patricia R.J. Griffen, Ram R. Krishna, M.D., Douglas D. Lee, M.D., Lorraine Mackstaller, M.D., William R. Martin, III, M.D., Dona Pardo, Ph.D., R.N., Paul M. Petelin, Sr., M.D., Germaine Proulx, and Amy J. Schneider, M.D.**
**12-yay, 0-nay, 0-abstain, 0-recuse, 0-absent.**
**MOTION PASSED.**

**MOTION: William R. Martin, III, M.D. directed Board Staff to open a new investigation regarding the physician and as part of the investigation, require Dr. Teague to undergo a neuropsychological evaluation within 21 days and, if appropriate, a Physician Assessment and Clinical Evaluation (PACE) evaluation.**
**SECONDED: Ram R. Krishna, M.D.**
**VOTE: 12-yay, 0-nay, 0-abstain, 0-recuse**

## FORMAL INTERVIEWS

| NO. | CASE NO. | COMPLAINANT v PHYSICIAN | | LIC. # | RESOLUTION |
|---|---|---|---|---|---|
| 5. | MD-05-0842A | AMB | RICHARD A. CIRELLI, M.D. | 27370 | Issue an Advisory Letter for failure to ensure the slides available for interpretation were adequately prepared. |

Richard A. Cirelli, M.D. was present with counsel, Barry Halpern from the law firm Snell and Wilmer.

Gerald Moczynski, M.D., Medical Consultant summarized the case for the Board. Staff found Dr. Cirelli should have obtained an outside opinion. A second OMC reviewed chart and felt Dr. Cirelli fell below the standard of care in this case. SIRC noted it was below the standard of care to misread a slide. Dr. Cirelli and his expert read the patient slides as benign when the OMC's read them as melanoma.

Dr. Cirelli gave an opening statement prior to receiving questions from the Board. He stated that he is always concerned for possibilities of melanoma. It was well documented that post diagnosis reinterpretation of slides are inherently biased. Dr. Cirelli presented the Board with similar artifacts and referred them to review as he described them to the Board.

Ram R. Krishna, M.D. led the questioning and addressed the physician's medical training and experience. Dr. Krishna noted that most dermatologists read there own slides and asked Dr. Cirelli if he did the same. Dr. Cirelli stated that he sends slides to a dermatologist. The patient was referred from another physician because of spots. Dr. Cirelli did a biopsy and it was noted that the lesion was larger than a typical mole, but it was symmetric. No family history or personal history was obtained. Dr. Cirelli informed

the Board that he sent the patient to an outside agency and then read the slides himself. At that time, Dr. Cirelli would read about twenty slides a day in his practice. The outside medical consultant, Dr Trepeta, noted there were two different lesions.

Dr. Cirelli informed the Board that it is not standard of care to exam the axilla of the patient unless they have a history of melanoma. Dr. Petelin asked why Dr. Cirelli chose to do a shave instead of a punch biopsy on the patient. Dr. Cirelli stated that he would only do a punch biopsy if the lymph nodes were suspicious enough, but this patient's lymph node did not have a malignant look to it.

Dr. Cirelli felt the slides he went off of were sufficient enough to make a diagnosis on this patient. Dr. Goldfarb asked if part of the tumor was being obscured by the artifact. Dr. Cirelli did not think so; he did not think it would have been hard to obscure something like that in the section that looked okay. Dr. Cirelli felt his actions were based on common practice; not all dermatologists do the same, but still felt it common.

During Mr. Halpern's closing statement, he stated that the issue that brought Dr. Cirelli before the Board is that whether or not he should be disciplined for slides that were irrefutably diagnostic. Dr. Trepeta told the courts that he found the slides diagnostically sufficient. There is no standard of care that prohibits a dermatologist from reading his own slides. Mr. Halpern stated that there is not any evidence that the lesion Dr. Cirelli excised was the same that was later diagnosed in 2003. Mr. Halpern stated that Dr. Cirelli cannot be found to have fallen held below the standard of care; the Board's own consultant noted that there was no patient harm in this case.

Ram R. Krishna, M.D. was concerned that Dr. Cirelli stated the slides were inadequately prepared. In such a case, he should have sent it back for better processing. Dr. Krishna noted there was a delay in diagnosis.

**MOTION: Ram R. Krishna, M.D. moved for a finding of unprofessional conduct in violation of A.R.S. § 32-1401(27)(q) – Any conduct that is or might be harmful or dangerous to the health of the patient or the public.**
**SECONDED: Douglas D. Lee, M.D.**
**Vote: 11-yay, 1-nay, 0-abstain, 0-recuse, 0-absent.**
**MOTION PASSED.**

Lorraine Mackstaller, M.D. spoke against the motion. She wondered if a re-biopsy would have been appropriate.

Robert P. Goldfarb, M.D. thought there was unprofessional conduct. On the other hand, he was impressed by one of the dermatologists who reviewed the slides and is used to seeing processing artifact and did not see melanoma. Dr. Goldfarb concurred with the motion.

Douglas D. Lee, M.D. spoke in favor of the motion. If Dr. Cirelli would have obtained an optimal slide and read it as normal, that clearly would have meant a lot. Dr. Lee thought Dr. Cirelli should have redone the slide or redid the biopsy.

Ram R. Krishna, M.D. felt there was delay in diagnosis because of the inadequate slide. Dr. Krishna felt torn between a disciplinary action versus an Advisory Letter.

**MOTION: Ram R. Krishna, M.D. moved to issue the physician an Advisory Letter for failure to ensure the slides available for interpretation were adequately prepared.**
**SECONDED: Robert P. Goldfarb, M.D.**
**ROLL CALL VOTE: Roll call vote was taken and the following Board Members were in favor of the motion: Patrick N. Connell, M.D., Dan Eckstrom, Robert P. Goldfarb, M.D., Patricia R.J. Griffen, Ram R. Krishna, M.D., Douglas D. Lee, M.D., M.D., William R. Martin, III, M.D., Dona Pardo, Ph.D., R.N., Paul M. Petelin, Sr., M.D., Germaine Proulx, and Amy J. Schneider, M.D. The following Board Members were against the motion: Lorraine Mackstaller, M.D.**
**Vote: 11-yay, 1-nay, 0-abstain, 0-recuse, 0-absent.**
**MOTION PASSED.**

| NO. | CASE NO. | COMPLAINANT v PHYSICIAN | | LIC. # | RESOLUTION |
|---|---|---|---|---|---|
| 6. | MD-05-0504B | AMB | MARTIN B. LANGFORD, M.D. | 21575 | Dismiss. |

Martin B. Langford, M.D. was present with counsel, Mary Pryor from the Cavanaugh law firm.

Kelly Sems, MD, Internal Medical Consultant summarized the case for the Board. She stated that both OMC's felt that Dr. Langford fell below the standard of care by not by not reviewing the available information more in depth when he was called. Staff found Dr. Langford failed to fully review the available material and failed to timely address profoundly low platelets and hemolytic anemia.

Patrick N. Connell, M.D. led the questioning. Dr. Connell noted that Dr. Langford's involvement in this case was on a night that Dr. Langford was on call with his medical group. Dr. Langford received two phone calls that night from the nursing staff. The first was regarding LO's low platelet count, and the second was primarily to inform him that there was going to be a delay in obtaining CNB

negative radiant platelets. Dr. Langford stated that he was never told LO had been moved or that she was having seizures. He stated that he was told she was requiring a lot of nursing care but did not remember being specifically told that she was weak and was having difficulty getting out of bed. If there were a suspicion of TTP, it was customary and standard in Dr. Langford's practice to have instituted plasma paresis. He stated it was not customary in his practice to leave the diagnosis of TTP with someone who was on call at eleven o'clock at night.

During Ms. Pryor's closing statement to the Board she stated that the only allegation was that he allegedly deviated from the standard of care by failing to adequately inform himself of the patient's condition and not instituting appropriate therapy. Dr. Langford did inform himself of LO's condition, he asked appropriate questions of his staff. Dr. Langford is used to seeing low platelet count patients. Ms. Pryor stated that Dr. Langford made sure LO was properly cared for and made sure she received the attention that she needed.

Dr. Sems stated that this was a difficult case and that it was very complex. However, given the information in the chart, she could not tell what the phone calls were regarding, it was not well documented. Dr. Sems stated that if she were reviewing the labs, at the bare minimum, she would have gone in and evaluated the patient herself.

Patrick N. Connell, M.D. felt this to be a tragic and unfortunate case and believed that the evidence suggested to him that LO was probably at some point in time salvageable. He stated it was hard to know what the nurses had communicated to Dr. Langford that night. Dr. Connell noted that other physicians were also involved in LO's care and did not feel that this rose to unprofessional conduct.

**MOTION: Patrick N. Connell, M.D. moved for dismissal.**
**SECONDED: Paul M. Petelin, Sr., M.D.**
**ROLL CALL VOTE: Roll call vote was taken and the following Board Members were in favor of the motion: Patrick N. Connell, M.D., Dan Eckstrom, Robert P. Goldfarb, M.D., Patricia R.J. Griffen, Ram R. Krishna, M.D., Douglas D. Lee, M.D., Lorraine Mackstaller, M.D., William R. Martin, III, M.D., Dona Pardo, Ph.D., R.N., Paul M. Petelin, Sr., M.D., Germaine Proulx, Amy J. Schneider, M.D.**
**Vote: 12-yay, 0-nay, 0-abstain, 0-recuse, 0-absent.**
**MOTION PASSED.**

| NO. | INTERVIEW | CASE NO. | COMPLAINANT v PHYSICIAN | | LIC. # | RESOLUTION |
|---|---|---|---|---|---|---|
| 7. | 3:45 p.m. | MD-05-0988A | H.C. | WILLIAM H. CASTRO, M.D. | 18402 | **Draft Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand for failure to personally evaluate prior to delivery of a VABC patient being induced with prostaglandin and for inadequate medical records.** |

HC was present and spoke before the interview. HC stated that as she looks back, she feels very fortunate that she had not suffered any disabilities and that she is still here. She asked what went wrong and why her daughter had to suffer from the complication. She believed it was through Dr. Castro's negligence that she had to suffer.

William H. Castro, M.D. was present with counsel, Stephen W. Myers from the law firm of Myers and Jenkins.

Ingrid Haas, M.D., Internal Medical Consultant summarized the case for the Board. Staff found Dr. Castro failed to properly monitor a patient in labor resulting in fetal distress.

Amy J. Schneider, M.D. led the questioning. Dr. Castro described what his practice was typically like at the time of the incident. He stated he was practicing with five associates at that time and when he was on call, he would be on call for all five. When one of the physicians would finish their shift, if there were any pending cases then they would be transferred to the next physician to come in. Dr. Castro stated that he was in the operating room at the Boswell Hospital at the time HC delivered, which was about seven miles away from his practice.

Robert P. Goldfarb, M.D. noted that Dr. Castro would leave it to the nursing staff to monitor patients while he was on call. Dr. Castro stated that was their standard practice. He stated that the nursing staff determined if there was an emergent issue for which HC needed to be seen right away. The patients are monitored by machines which are monitored by the nurses and the physicians have web access if they would need to examine a strip. Dr. Castro stated that the physicians would only monitor the patients by the internet or telephone; they did not personally examine their patients.

Douglas D. Lee, M.D. noted that in the year 2000, physicians were using different guidelines for vaginal birth after Cesarean (VBAC). In 2000, HC would have been considered a patient with additional co-morbidities. Dr. Castro stated that, in his practice, patients are treated the same as everyone else. Ingrid Haas, M.D., Internal Medical Consultant stated that she would have differentiated a patient who presented for a normal labor from a patient who had a history of cesarean sections presenting for an induction. Dr. Haas believed that in 1999 when that ACOG guideline had been published, there was information available for it.

Patricia R.J. Griffen was curious as to whether or not there was communication with the patient at the time she had been transferred to another physician in the practice. Dr. Castro stated that it was customary in his practice for the patients to know that other physicians within the practice could be attending.

Paul M. Petelin, Sr., M.D. stated that he was having trouble understanding why Dr. Castro would not take the time and effort to see HC. Dr. Castro stated that he was in communication with the nursing staff, there was no evidence of fetal distress, and he felt he had nothing more to contribute. He stated that his nursing staff knows their craft well.

Robert P. Goldfarb, M.D. asked Dr. Haas if it was the standard of care for an obstetrician to admit the patient to the hospital and only communicate by internet or telephone and if it were below standard to hand over cases to someone else with no update in the chart available for the next physician. Dr. Haas believed that only communicating by internet or phone falls below the standard. She stated that within a call group communications are often verbal. If you were not able to contact anyone you would need to obtain the patient's status from the nurse's notes.

During Mr. Myers' closing statements to the Board, he stated that the initial complaint did not ask for medical records. Mr. Myers noted that at the time, the ACOG guidelines required a physician to be available within thirty minutes and Dr. Castro was available within that amount of time if need be. He stated there is nothing in the Board's statutes about documenting transferring patients to associates within a practice, which was usually brief.

Dr. Hass noted that in reviewing the 1999 ACOG guidelines the criteria for who can consider a VBAC at that time is listed. She stated the definition of "immediately available" was a physician who would be capable of monitoring or performing an emergency Cesarean Section.

Amy J. Schneider, M.D. believed there was unprofessional conduct regarding the medical records. She stated that the phenyl flow sheet could have been used in lieu of a history and physical, however, the flow sheet had not been updated for three weeks. She felt it below the standard of care even in the year 2000 to admit a patient for induction of labor who has had previous Cesarean section and not see the patient any time during her labor.

**MOTION: Amy J. Schneider, M.D. moved for a finding of unprofessional conduct in violation of A.R.S. § 32-1401(27)(e)- Failing or refusing to maintain adequate records on a patient and A.R.S. § 32-1401(27)(q) – Any conduct that is or might be harmful or dangerous to the health of the patient or the public.**
**SECONDED: Germaine Proulx**

**MOTION: William R. Martin, III, M.D. moved to go into executive session.**
**SECONDED: Ram R. Krishna, M.D.**
**Vote: 12-yay, 0-nay, 0-abstain, 0-recuse, 0-abstain.**
**MOTION PASSED.**

The Board went into Executive Session for legal advice at 5:19 p.m.
The Board returned to Open Session at 5:22 p.m.
No deliberations or discussions were made during Executive Session.

**Vote: 12-yay, 0-nay, 0-abstain, 0-recuse, 0-absent.**
**MOTION PASSED.**

Amy J. Schneider, M.D. felt it was not appropriate that HC was only evaluated by Dr. Castro's nursing staff; she felt this to fall below the standard of care. Dr. Schneider felt it mitigating that Dr. Castro was in contact by phone and that ultimately his partner, another physician, was present at the delivery. She felt it also mitigating that the infant in question suffered from a pneumothorax, but it was not likely a result of the quality of care during labor and delivery. She stated that the major issue is not that Dr. Castro did not see the patient in labor; it is that he did not see the patient in labor that required a higher level of surveillance due to her previous Cesarean.

**MOTION: Amy J. Schneider, M.D. moved to issue the physician an Advisory Letter for failure to see a patient who required a higher level of surveillance. This does not rise to the level of discipline.**
**SECONDED: Lorraine Mackstaller, M.D.**

Ram R. Krishna, M.D. spoke against the motion. He stated that the mitigating factors did not outweigh the allegations that were presented. Robert P. Goldfarb, M.D. also spoke against the motion and agreed with Dr. Krishna. Patrick N. Connell, M.D. stated that he agreed with Drs. Krishna and Goldfarb and spoke against the motion. Dr. Connell noted that the Board has seen this perhaps more times than they should where physicians have delegated their role to ancillary providers. Dona Pardo, Ph.D., R.N.

also spoke against the motion. She stated that Dr. Castro had previously been issued an Advisory Letter for failure to timely evaluate a patient. She thought this was a similar situation and would support a Letter of Reprimand.

Amy J. Schneider, M.D. asked that since his Advisory Letter in 2005, this incident occurred in 2000, could his previous Advisory Letter still be taken into account. William R. Martin, III, M.D. replied by stating yes, it could be considered.

**ROLL CALL VOTE: Roll call vote was taken and the following Board Members were in favor of the motion: Lorraine Mackstaller, M.D. and Amy J. Schneider, M.D. The following Board Members were against the motion: Patrick N. Connell, M.D., Dan Eckstrom, Robert P. Goldfarb, M.D., Patricia R.J. Griffen, Ram R. Krishna, M.D., Douglas D. Lee, M.D., William R. Martin, III, M.D., Dona Pardo, Ph.D., R.N., Paul M. Petelin, Sr., M.D., and Germaine Proulx.**
**Vote: 2-yay, 10-nay, 0-abstain, 0-recuse, 0-absent.**
**MOTION FAILED.**

**MOTION: Ram R. Krishna, M.D. moved for Draft Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand for failure to personally evaluate prior to delivery of a VBAC patient being induced with prostaglandin gel, and for inadequate medical records.**
**SECONDED: Patricia R.J. Griffen**
**ROLL CALL VOTE: Roll call vote was taken and the following Board Members were in favor of the motion: Patrick N. Connell, M.D., Dan Eckstrom, Robert P. Goldfarb, M.D., Patricia R.J. Griffen, Ram R. Krishna, M.D., Douglas D. Lee, M.D., Lorraine Mackstaller, M.D., William R. Martin, III, M.D., Dona Pardo, Ph.D., R.N., Paul M. Petelin, Sr., M.D. and Germaine Proulx. The following Board Members were against the motion: Amy J. Schneider, M.D.**
**Vote: 11-yay, 1-nay, 0-abstain, 0-recuse, 0-absent.**
**MOTION PASSED.**

## FORMAL HEARING MATTERS – CONSIDERATION OF ALJ RECOMMENDED DECISION

| NO. | CASE NO. | COMPLAINANT v PHYSICIAN | | LIC. # | RESOLUTION |
|---|---|---|---|---|---|
| 1. | MD-06-0340A<br>MD-05-0416A | J.C.<br>AMB | KING T. LEUNG, M.D. | 10262 | Accept the ALJ's recommended Findings of Fact, Conclusions of Law as amended and the Order for Revocation. |

King T. Leung, M.D. was not present during the consideration of this case.

Anne Froedge, Assistant Attorney General summarized the case for the Board. Dr. Leung failed to appear for his Formal Hearing. Ms. Froedge informed the Board that in his absence, Dr. Leung submitted a letter requesting the Administrative Law Judge (ALJ) accept it as evidence, which the ALJ allowed. The ALJ upheld the summary suspension and recommended revocation. She requested the Board adopt the recommendation of the ALJ with the modification as set forth in the State's Motion. Christine Cassetta, Board Legal Counsel stated Finding of Fact #8 reads Dr. Leung's 'failure to not look above' and the double-negative indicates he did look above, but that is not the case. The ALJ adopted the Board's Summary Suspension Order and that Order did not have "not" in that sentence. She requested the Board delete the word 'not' in that sentence.

**MOTION: Ram R. Krishna, M.D. moved to adopt the ALJ's recommended Findings of Fact, Conclusions of Law and Order as amended. The state recommended modification of findings of fact No. 23 to read as follows: 23. The standard of care requires a physician to perform routine health maintenance; ~~to perform a colonoscopy~~ ~~in~~ *adequately evaluate* a patient who presents with a history of rectal bleeding; to treat a patient's elevated cholesterol; and to control a patient's blood pressure.**
**SECONDED: Douglas D. Lee, M.D.**
**Vote: 12-yay, 0-nay, 0-abstain, 0-recuse, 0-absent.**
**MOTION PASSED.**

**MOTION: Ram R. Krishna, M.D. moved to adopt the ALJ's recommended Order for Revocation.**
**SECONDED: Patrick N. Connell, M.D.**
**Vote: 12-yay, 0-nay, 0-abstain, 0-recuse, 0-absent.**
**MOTION PASSED.**

## Thursday, April 12, 2007

### Call to Order
The meeting was called to order at 8:00 am

### Roll Call
The following Board Members were present: Patrick N. Connell, M.D., Dan Eckstrom, Robert P. Goldfarb, M.D., Patricia R.J. Griffen, Ram R. Krishna, M.D., Douglas D. Lee, M.D., Lorraine Mackstaller, M.D., William R. Martin, III, M.D., Dona Pardo, Ph.D.,

R.N., Paul M. Petelin, Sr., M.D., Dona Pardo, Ph.D., R.N., Paul M. Petelin, Sr., M.D., Germaine Proulx and Amy J. Schneider, M.D.

## Call to Public

There was no one present for Call to Public.

## FORMAL INTERVIEWS

| NO. | CASE NO. | COMPLAINANT v PHYSICIAN | | LIC.# | RESOLUTION |
|---|---|---|---|---|---|
| 1. | MD-05-0721A | AMB | FELIPE A. CECENA, M.D. | 15243 | Draft Findings of Fact, Conclusions of Law and Order for Decree of Censure for failure to timely see a critically ill patient, for making a misleading statement in the medical records. One Year Probation to include 10 hours CME in ethics. The Probation will end upon completion of the CME. |

Felipe A. Cecena, M.D. was present with counsel, Stephen W. Myers from the law firm Myers and Jenkins.

Kelly Sems, MD, Internal Medical Consultant summarized the case for the Board. During an interview he stated that he did not visit the patient since he was sick himself

William R. Martin, III, M.D. stated he has seen consultations with Dr. Cecena, but will not interfere with his ability to adjudicate the case.

Dr. Cecena gave an opening statement to the Board prior to receiving questions. He stated that the night of October 24, 2003 will remain engraved in his mind and heart for the rest of his life. That was the date for the first time in his unblemished career of 44 years he was unable to be at the bedside of a patient in need of medical care. Dr. Cecena stated that through his efforts, the patient was finally transferred to a facility with excellent vascular surgical team at the Arizona Heart Hospital. Dr. Cecena felt he never abandoned the patient. He stated that orders were given not only to the nurse but also to an excellent emergency physician who was at the patient's bedside. Based upon the description of the clinical status of the patient provided to Dr. Cecena by the ICU nurse and the emergency physician, he stated it was clear to him that the patient needed a vascular surgeon and not an interventional cardiologist.

Lorraine Mackstaller, M.D. led the questioning. Dr. Cecena stated that before he went to Maricopa Medical Center, there were about four or five incidents of the same nature of this patient. He stated he was surprised when he was contacted, he did not know anything about this patient. He stated that no one communicated the patient's chart to him. Dr. Cecena stated he was ill with food poisoning and that is why he did not go in to see the patient. Dr. Cecena admitted that he was less than honest when he spoke to the medical committee and told them he was occupied, rather than informing them that he was ill. Dr. Mackstaller noted the patient's discharge summary dated January 24, 2004 and asked Dr. Cecena where the discharge came from and why it was generated. Dr. Cecena stated the summary was generated by the person who knew patient, dealt with the patient, and who was in charge is the one who dictates the discharge summary. He stated that since he was the physician in charge, he signed and dictated this patient's discharge summary.

Dr. Mackstaller asked Dr. Cecena how he has changed his practice and if he is not well how he is being covered by his practice. She also asked him if he has changed his recordkeeping. Dr. Cecena thought his recordkeeping was good. He stated that it had been a problem for the past three years for him being on call with only one other physician for three different hospitals. He brought this issue to the attention of the head of the different departments informing them that they are extremely busy. Dr. Cecena stated that he wanted to join a group in which he can have full coverage, if not, then not join a group at all.

Dr. Cecena stated that he thought the ultimate cause of her death was blood loss or significant anemia that contributed further to her cardiac problems. He stated that the situation did not seem emergent.

Dr. Cecena stated that when he worked with people he trusted and when his nurses had a superb history, he tended to rely very much on them. Dr. Cecena not only relied on the nursing staff, he also relied on the emergency room physician, who was not a. cardiologist. Dr. Goldfarb stated that Dr. Cecena should have come in and assessed the problem and given the appropriate care to that patient in the shortest period of time. Dr. Goldfarb stated that Dr. Cecena had been practicing for 44 years and should know not to write orders on a chart after the patient dies. He also stated that Dr. Cecena had someone write a letter to a medical executive peer review committee which was a lie.

Dr. Cecena did not know that it was below the standard of care to document orders in a patient's chart after the fact. He felt that the care provided by the emergency room physician was stabilizing the patient. He stated that in his 44 years of practicing, this was the only time he was kept from seeing a patient.

William R. Martin, III, M.D., felt Dr. Cecena's ethical issues were egregious and was in doubt of Dr. Cecena's competency.

In his closing statement, Mr. Myers stated that the undated order was not intended to be misleading. Dr. Cecena did not testify that he was aware of the standard of care. He had never been named in a medical malpractice case in his 44 years of practice. Mr. Myers also stated that Dr. Cecena has never been involved in a Board complaint either.

Lorraine Mackstaller, M.D. stated that the issues of this case were primarily with dishonesty and quality of care. She believed that LO was deprived of the opportunity to survive.

**MOTION: Lorraine Mackstaller, M.D. moved for a finding of unprofessional conduct in violation of A.R.S. § 32-1401(27)(e)- Failing or refusing to maintain adequate records on a patient, A.R.S. § 32-1401(27)(ll) - Conduct that the board determines is gross malpractice, repeated malpractice or any malpractice resulting in the death of a patient, A.R.S. § 32-1401(27)(t)- Knowingly making any false or fraudulent statement, written or oral, in connection with the practice of medicine or if applying for privileges or renewing an application for privileges at a health care institution, and A.R.S. § 32-1401(27)(q)- Any conduct that is or might be harmful or dangerous to the health of the patient or the public.**
**SECONDED: Ram R. Krishna, M.D.**
**Vote: 12-yay, 0-nay, 0-abstain, 0-recuse, 0-absent.**
**MOTION PASSED.**

**MOTION: Lorraine Mackstaller, M.D. moved for Draft Findings of Fact, Conclusions of Law and Order for Decree of Censure for failure to timely see a critically ill patient, for making a misleading statement in the medical records. One year Probation to include 10 hours CME in ethics. The Probation will end upon completion of the CME.**
**SECONDED: Ram R. Krishna, M.D.**

Douglas D. Lee, M.D. asked the Board if they felt CME would be sufficient. Dr. Lee felt it egregious that Dr. Cecena did not feel it was wrong that he documented in LO's record after she died. He wondered how many other patient records he had written notes in post the day of. Dr. Lee believed that Dr. Cecena did abandon the patient in this case.

Ram R. Krishna, M.D. agreed with Dr. Lee. He noted that Dr. Cecena did admit to, on one or more occasions, documenting in the record after the fact. Dr. Krishna felt 10 would be enough and spoke in favor of the motion.

Robert P. Goldfarb, M.D. instructed Board Staff to open an investigation on Dr. Ashar, an associate of Dr. Cecena's that was involved in this case.

Paul M. Petelin, Sr., M.D. wondered if we had any connection to the Arizona hospital system, he felt there was also failure on the part of St. Luke's Hospital to not report to the Board of Dr. Cecena's actions.

Christine Cassetta, Board Legal Counsel stated that if the Board determined the facility failed to report as required, the statute requires the Board to report the facility to the Department of Health Services.

Dr. Lee asked what the best venue would be to address what seemed to be an occurring issue of transferring patients. Ms. Cassetta suggested the Board could form a Subcommittee to address this issue. The Subcommittee could write guidelines on transferring patients similar to what the Board adopted for prescribing controlled substances.

Timothy Miller, J.D., Executive Director informed the Board that the Department of Health Services had looked into this issue several times but has yet to develop any type of policy in its regard.

Ram R. Krishna, M.D. wondered if the Board had any jurisdiction over the physician who had wrote the fraudulent letter for Dr. Cecena. Ms. Cassetta stated that the Board can also open an investigation on this physician if the Board felt it necessary. Dr. Martin agreed with Dr. Krishna and stated the Board will leave it to Mr. Miller to look into the issue.

**ROLL CALL VOTE: Roll call vote was taken and the following Board Members were in favor of the motion: Patrick N. Connell, M.D., Dan Eckstrom, Robert P. Goldfarb, M.D., Patricia R.J. Griffen, Ram R. Krishna, M.D., Douglas D. Lee, M.D., Lorraine Mackstaller, M.D., William R. Martin, III, M.D., Dona Pardo, Ph.D., R.N., Paul M. Petelin, Sr., M.D., Germaine Proulx, Amy J. Schneider, M.D.**
**Vote: 12-yay, 0-nay, 0-abstain, 0-recuse, 0-absent.**
**MOTION PASSED.**

| NO. | CASE NO. | COMPLAINANT v PHYSICIAN | | LIC. # | RESOLUTION |
|---|---|---|---|---|---|
| 2. | MD-05-0504A | AMB | DAVID S. MENDELSON, M.D. | 12837 | Advisory Letter for failure to personally evaluate a patient with profound thrombocytopenia. |

David S. Mendelson, M.D. was present with counsel, Paul Forrest from the law firm Holloway, Odegard, Forrest, Kelly & Kasparek.

Prior to the interview, the Board addressed a Motion for Good Cause for submission of additional materials that the physician's attorney had previously filed.

**MOTION: Robert P. Goldfarb, M.D. moved to accept the Motion for Good Cause for submission of additional materials.**
**SECONDED: Patrick N. Connell, M.D.**
**Vote: 12-yay, 0-nay, 0-abstain, 0-recuse, 0-absent.**
**MOTION PASSED.**

Kelly Sems, MD, Internal Medical Consultant summarized the case for the Board. Staff found Dr. Mendelson deviated from the standard of care by failing to order labs in a timely fashion and failed to treat a patient with low platelet count in a timely fashion.

Dr. Mendelson gave an opening statement prior to receiving questions from the Board Members. Dr. Mendelson felt he acted reasonably for this patient. He stated that since Hematologists do not do biopsies during the evaluation of thrombocytopenia, other findings have to support the diagnosis. The cause of death was not certain, but the hematologic aspects for this case did not contribute to the death of the patient. He stated that the Board should reject that this settlement of the lawsuit was an admission to malpractice and error. In LL's care, two physicians had tended to her in the previous ten to twelve hours. The notes did not report acute bleeding, mental changes or neurological changes.

Patrick N. Connell, M.D. led the questioning. Dr. Mendelson stated that he did know the hospitalist, Dr. Palnotti, very well. He stated he was aware of the hematology consultation request made by Dr. Palnotti, but the communication was not clear. The order in the chart said consult today, not stat. Dr. Miranda was the one initially contacted about LL. Dr. Mendelson did not think LL had TTP. Dr. Connell noted that, if treated early and promptly, TTP has the potential for a fairly good outcome. Dr. Mendelson stated it was a complicated treatment and agreed that with appropriate treatment the prognosis is much better. Dr. Mendelson did not evaluate LL; his nurse did the assessment and would have obtained LL's history. Dr. Mendelson depended on her to be his observer on whether the patient was stable.

Paul M. Petelin, Sr., M.D. asked Dr. Mendelson what he thought the sequence was that led to LL's death. Dr. Mendelson stated he did no know whether she in fact had a medication reaction or if there was some other deterioration.

Lorraine Mackstaller, M.D. asked Dr. Mendelson if LL had schystocytes. Dr. Mendelson stated that the pathologist may have suggested so but thought the conclusion was that she did.

Dr. Mendelson understood that a platelet transfusion had already been ordered for LL. Once the transfusion is ordered, Dr. Mendelson would only be contacted if there were any change in LL's status. Dr. Mendelson stated he would then visit the patient the morning after to see what had transpired since the transfusion. Dr. Goldfarb asked Dr. Mendelson if the he had not heard anything after the transfusions, would he assume another physician had taken over. Dr. Mendelson stated that he would have eventually talked to the other physician in the morning to give him his direct report.

Dr. Connell asked Dr. Sems what her opinion was. Dr. Sems stated that, in her personal opinion, after looking at all of the facts it would be most likely that LL had lupus with TTP, which is very rare. She stated that she dealt with two similar cases in her own practice previously and she had consultants on the case within twenty four hours. Fortunately, both patients made it through. At the point in time where Dr. Mendelson was, given the information available, she questioned why he did not go in and do a peripheral smear to clarify what was on that peripheral smear so that he could further delineate the reason for hemolysis.

In his closing statements, Mr. Forrest stated Dr. Mendelson was not named as a defendant in the lawsuit, his practice was. The Board needed to understand that Dr. Mendelson did not know of Dr. Miranda's involvement. Mr. Forrest requested the Board to consider something less than Censure for Dr. Mendelson.

Dr.Connell noted that Dr. Mendelson's group granted consent to settle in the lawsuit. Dr. Mendelson himself refused consent to settle. When MICA allocated moneys to be paid, they allocated some moneys to him and that is what was reported to the National Practitioner's Databank.

Dr. Connell felt this patient deserved a same day consult. He believed that the standard of care would have required the physician to personally evaluate the patient on the date requested.

**MOTION: Patrick N. Connell, M.D. moved for a finding of unprofessional conduct in violation of A.R.S. § 32-1401(27)(q)- Any conduct that is or might be harmful or dangerous to the health of the patient or the public.**
**SECONDED: Paul M. Petelin, Sr., M.D.**

Ram R. Krishna, M.D. felt Dr. Mendelson was pretty conscientious in the way he answered questions and his knowledge. Dr. Krishna also felt that the hospitalist involved wrote the consult to be seen that same day. Dr. Krishna spoke against the motion. Robert P. Goldfarb, M.D. stated he was not for or against the motion but did agree with Dr. Krishna stating he brought up a very

good point. If the hospitalist really felt that he needed Dr. Mendelson, he should have called him directly or noted that he needed a stat consult. Dona Pardo, Ph.D., R.N. wondered if the outcome would have been prevented had Dr. Mendelson gone in to see LL that night. Dr. Connell stated that had Dr. Mendelson gone in and evaluated LL and looked at her peripheral smear, he may have concluded that she didn't have TTP. He may have concluded she had lupus and started her on steroids or plasma exchange. It seemed to Dr. Connell that LL deserved an evaluation early on. Lorraine Mackstaller, M.D. was concerned that the physician who requested the consult in that he should have said this was really important and opined that he was the one at fault. She felt the hospitalist had an obligation to convey emergency. Amy J. Schneider, M.D. also agreed that the physician who ordered the consult should have relayed some kind of urgency. Paul M. Petelin, Sr., M.D. noted that when Dr. Mendelson got the call, he realized that the thrombocytopenia was already being addressed by platelet infusion. One advantage that might have been gained was that he is a hematologist, he had the knowledge greater than any other physician who tended to LL at that time and maybe he could have gone in to see if maybe something might have red flagged him. Dr. Petelin felt LL was denied the opportunity of his expertise by his failure to be present at her bedside. Douglas D. Lee, M.D. agreed that Dr. Mendelson going in may have made a difference. Dr. Lee spoke in support of the motion. Dr. Krishna stated that the consulting physician has the final say in the care of the patient, and if he thought he was not satisfied with the way that things were progressing, he could have re-consulted the physician stating so. William R. Martin, III, M.D. agreed with the comment made earlier about when an urgent or an emergent consult is needed it needs to be physician to physician.

Dr. Sems added that it was not just the low platelet count information that Dr. Mendelson had available. There was also an abnormal urinalysis and there was also evidence of hemolysis. The cause of hemolysis was not clear at that point in time. She was not sure if Dr. Mendelson truly knew of this, if he truly asked the nurse about it, or if he just knew about the platelets but he did have more information.

Dr. Mendelson stated that his sister had TTP a little over 25 years ago, and it took about three or four days to actually make the diagnosis and she is now a survivor. There is no patient with thrombocytopenia that he does not think about the diagnosis of TTP. He was assured that LL's needs were being addressed and maybe that was not the assumption he should have made. He felt that he needed to make sure LL got to the point where other evaluations were going to kick in.

**Vote: 7-yay, 4-nay, 0-abstain, 0-recuse, 0-absent.**
**MOTION PASSED.**

Patrick N. Connell, M.D. stated that after considerable debate and understanding of the complexities of this case, he did not feel this rose to the level of discipline. Dr. Connell noted that the potential harm is that with a platelet count of five thousand had a threatening and emergent illness and would require prompt attention and consultation

**MOTION: Patrick N. Connell, M.D. moved to issue the physician and Advisory Letter for failure to personally evaluate a patient with profound thrombocytopenia.**
**SECONDED: Paul M. Petelin, Sr., M.D.**

**Drs. Goldfarb and Krishna stated they both support the motion.**

**ROLL CALL VOTE: Roll call vote was taken and the following Board Members were in favor of the motion: Patrick N. Connell, M.D., Dan Eckstrom, Robert P. Goldfarb, M.D., Patricia R.J. Griffen, Ram R. Krishna, M.D., Douglas D. Lee, M.D., Lorraine Mackstaller, M.D., William R. Martin, III, M.D., Dona Pardo, Ph.D., R.N., Paul M. Petelin, Sr., M.D., Germaine Proulx, Amy J. Schneider, M.D.**
**Vote: 12-yay, 0-nay, 0-abstain, 0-recuse, 0-absent.**
**MOTION PASSED.**

| NO. | CASE NO. | COMPLAINANT v PHYSICIAN | | LIC. # | RESOLUTION |
|---|---|---|---|---|---|
| 3. | MD-05-0442A | AMB | ASHISH PERSHAD, M.D. | 25732 | Advisory Letter for failure to properly supervise the technical aspects of an interventional heart catheterization. |

Ashish Pershad, M.D. was present with counsel, Stephen W. Myers from the law firm Myers and Jenkins.

William Wolf, M.D., Medical Consultant summarized the case for the Board. The medical consultant who reviewed this case found that Dr. Pershad deviated from the standard of care by failing to appropriately purge the system of air and by failing to obtain an adequate pressure tracing before engaging the ostium of the left coronary artery.

Dr. Pershad stated he had spent many long agonizing hours trying to understand the circumstances around this case. Dr. Pershad briefly described his training to the Board. This was a complicated procedure, teamwork and cooperation is crucial along with good communication. Dr. Pershad stated that he had been described by his peers and supervisors during training as to go above and beyond the call of duty in the care of this patient. His philosophy was to always treat his patients the way he would his own family.

Lorraine Mackstaller, M.D. led the questioning. This patient was referred to Dr. Pershad by another interventional cardiologist from Yuma, Arizona. Dr. Mackstaller asked Dr. Pershad what state the equipment was in when he would enter the catheterization lab. He stated that it depended on the state of preparation of how the team was prepared for the case. Dr. Pershad stated that the patient was in the waiting area during the preparation of the catheterization lab and was then moved to the lab once it was ready.

Paul M. Petelin, Sr., M.D. had Dr. Pershad explain to him how the procedure works. Dr. Pershad stated that after he placed the wire on the back table, when he turned around he looked up and saw there was no pressure tracing. At that point he told the patient that she was going to start feeling dizzy. The rest of the time of the procedure was spent resuscitating the patient. After an hour and a half of hectic resuscitation, the patient arrested. Dr. Pershad stated that he was at a loss of words to fully explain the situation. He stated he did not even have enough time to fully digest what had just happened.

Douglas D. Lee, M.D. asked Dr. Pershad if he gave instructions to the technician or if the technician acted on his own. Dr. Pershad stated in his usual practice, he would do it himself since he was the one dealing with the manifold. He stated the technician did what she thought was customary to her which was to flush the catheter. She was doing her normal routine but the catheter was still in the patient. Dr. Lee asked if the technician knew the catheter was still in the patient. Dr. Pershad thought she was so used to flushing the catheter that it was like a second nature for her. She did it without realizing the line she was injecting. Dr. Lee asked why the technician injected the catheter while still in the patient and without Dr. Pershad's knowledge. Dr. Pershad stated that a lot of the interventional physicians ask their technicians to do it for them.

Paul M. Petelin, Sr., M.D. noted that the records read the progression a little different that Dr. Pershad's testimony. Dr. Petelin stated that it seemed Dr. Pershad was actively performing the angiogram and during the process then, the patient developed ventricular fibrillation. Dr. Pershad stated that his intent was not to deceive or hide or change or manufacture. He stated perhaps the record represented more accurately what happened.

In his closing statements to the Board, Mr. Myers stated that in his experience it is usually fairly certain as to why or how something went wrong, that was not the case here. He stated this case occurred in 2003 and it was not then or now of the standard to require a physician to preoperatively double check that the equipment being used has been flushed. Mr. Myers noted that the nurse technician's argument is not supported by the record. He stated that Dr. Pershad is very troubled and saddened by what happened. Mr. Myers stated that something must have happened before Dr. Pershad injected the dye to abrupt termination of the two vessels.

**MOTION: Lorraine Mackstaller, M.D. moved for a finding of unprofessional conduct in violation of A.R.S. § 32-1401(27)(q)- Any conduct that is or might be harmful or dangerous to the health of the patient or the public.**
**SECONDED: Ram R. Krishna, M.D.**

Robert P. Goldfarb, M.D. did not think the Board had enough evidence that Dr. Pershad had committed unprofessional conduct. Dr. Goldfarb noted that Dr. Pershad had been forthright during his interview. He spoke against the motion.

William R. Martin, III, M.D. was impressed by Dr. Pershad's passionate explanation of the procedure and agreed with Dr. Goldfarb that he did not know this could have occurred other than the explanation he gave during his interview.

Lorraine Mackstaller, M.D. stated she could not find that the catheter was documented by the nursing staff.

**Vote: 3-yay, 9-nay, 0-abstain, 0-recuse, 0-absent.**
**MOTION FAILED.**

**MOTION: Lorraine Mackstaller, M.D. moved for dismissal.**
**SECONDED: Robert P. Goldfarb, M.D.**

Paul M. Petelin, Sr., M.D. did not feel that this rose to the level of discipline, but felt the cardiologist had some obligation to be certain that the manifold was properly purged of air as well as the catheter. Dr. Petelin spoke against the motion and recommended an Advisory Letter. Dr. Petelin noted that Dr. Pershad has since changed his technique and has become more attentive.

Ram R. Krishna, M.D. spoke against the motion and agreed that an Advisory Letter would be more appropriate. He noted there was patient harm. Dr. Lee agreed to the Advisory Letter and did not support the dismissal. Dr. Pardo also agreed.

William R. Martin, III, M.D. felt that an Advisory Letter would be appropriate so this could be tracked. He stated he would ultimately support an Advisory Letter.

**Vote: 4-yay, 8-nay, 0-abstain, 0-recuse, 0-absent.**
**MOTION FAILED.**

**MOTION: Lorraine Mackstaller, M.D. moved to issue an Advisory Letter for failure to properly supervise the technical aspects of an interventional heart catheterization.**
**SECONDED: Ram R. Krishna, M.D.**
**ROLL CALL VOTE: Roll call vote was taken and the following Board Members were in favor of the motion: Patrick N. Connell, M.D., Dan Eckstrom, Ram R. Krishna, M.D., Douglas D. Lee, M.D., Lorraine Mackstaller, M.D., William R. Martin, III, M.D., Dona Pardo, Ph.D., R.N., Paul M. Petelin, Sr., M.D., Germaine Proulx, and Amy J. Schneider, M.D. The following Board Member abstained from the motion: Robert P. Goldfarb, M.D.**
**Vote: 11-yay, 0-nay, 1-abstain, 0-recuse, 0-absent.**
**MOTION PASSED.**

| NO. | CASE NO. | COMPLAINANT v PHYSICIAN | | LIC. # | RESOLUTION |
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| 4. | MD-06-0129A | L.S. | GEORGE SEIN, M.D. | 13863 | Draft Findings of Fact, Conclusions of Law and Order for Letter of Reprimand for failure to appropriately communicate results of an abnormal laboratory test, delaying the diagnosis of prostate cancer. |

George Sein, M.D. was present with legal counsel, Tome Slutes from the law firm Slutes, Sakrison and Hill.

Robert P. Goldfarb, M.D. stated that he knew Dr. Sein personally and professionally but did not feel it would affect his ability to adjudicate this case.

Roderic Huber, M.D., Medical Consultant summarized the case for the Board. Staff found Dr. Sein failed to communicate a significantly abnormal lab result and therefore, the diagnosis of prostatic cancer was delayed.

Douglas D. Lee, M.D. led the questioning. Dr. Sein stated that he had medical assistants assisting him in his office, but all test results would come to his personal attention. He would review the results and if the patient had a return appointment, he would then file the chart away with the lab and wait until the patient's next visit. He stated that this was his practice for the past 24 years. Dr. Lee informed Dr. Sein that it is his responsibility to communicate test results to the patients. If the patients do no call back or schedule return appointments, it is important for him to call and inform them of the abnormal lab results. Dr. Sein stated that the chart would come to him and if it were important, he would then specifically request the patient come back to his office. It was not unusual for patients to miss appointments in his office. If a patient made an appointment for a specific date and did not come in, it was considered a no call no show. Dr. Lee asked Dr. Sein if it were more imperative to actively seek out a patient with abnormal lab results when he or she has demonstrated a history of not making follow up appointments. Dr. Sein made the presumption that the patient would come back. Dr. Lee noted that it was documented in the record that this patient was not reliable on coming back to the office and stated that this patient seemed to be non-compliant. Dr. Sein stated that he now has a mechanism in his practice where he would initiate contact instead of waiting for the patient to come back. He did not want to fluster the patient with information over the phone and would rather have them come in right away to defuse the situation.

Lorraine Mackstaller, M.D. noted that it was documented in the record that this patient's brother had prostate cancer.

Paul M. Petelin, Sr., M.D. noted that Dr. Sein was issued an Advisory Letter ten years ago for failure to follow up on abnormal lab results. Dr. Petelin stated that Dr. Sein has obviously not learned anything from ten years ago. Dr. Sein did not remember receiving the Advisory Letter ten years ago.

During his closing statements to the Board, Dr. Sein stated that he made a judgment call and decision and now has to live with it. He stated it was in good intentions and never thought the patient would not come back. Dr. Sein regretted that he was not made aware that the patient would never come back.

**MOTION: Douglas D. Lee, M.D. moved for a finding of unprofessional conduct under A.R.S. § 32-1401(27)(ll)- Conduct that the board determines is gross negligence, repeated negligence or negligence resulting in harm to or the death of a patient.**
**SECONDED: Patrick N. Connell, M.D.**

**Vote: 12-yay, 0-nay, 0-abstain, 0-recuse, 0-absent.**
**MOTION PASSED.**

Dr. Lee felt an aggravating factor was that Dr. Sein was issued an Advisory Letter previously for failure to follow up on abnormal lab results.

**MOTION: Douglas D. Lee, M.D. moved for Draft Findings of Fact, Conclusions of Law and Order for Letter of Reprimand for failure to appropriately communicate results of an abnormal laboratory test, delaying the diagnosis of prostate cancer.**
**SECONDED: Patrick N. Connell, M.D.**

**ROLL CALL VOTE: Roll call vote was taken and the following Board Members were in favor of the motion: Patrick N. Connell, M.D., Dan Eckstrom, Robert P. Goldfarb, M.D., Patricia R.J. Griffen, Ram R. Krishna, M.D., Douglas D. Lee, M.D., Lorraine Mackstaller, M.D., William R. Martin, III, M.D., Dona Pardo, Ph.D., R.N., Paul M. Petelin, Sr., M.D., Germaine Proulx, and Amy J. Schneider, M.D.**
**Vote: 12-yay, 0-nay, 0-abstain, 0-recuse, 0-absent.**
**MOTION PASSED.**

| NO. | CASE NO. | COMPLAINANT v PHYSICIAN | | LIC.# | RESOLUTION |
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| 5. | MD-05-1211A | J.C. | JAMES S. GOUGH, M.D. | 7317 | Continue the matter to review the quality of care issues and bring the matter back to the Board. |

James S. Gough, M.D. was present with counsel, Gary Fadell from the law firm Fadell, Cheney & Burt.

Tina Geiser, Senior Investigator summarized the case for the Board. Staff found Dr. Gough failed to timely provide patient medical records upon receipt of written authorization. Ms. Geiser noted that Dr. Gough relied on the advice of legal counsel to not provide the records to the patient but the responsibility lied with the doctor.

During Dr. Gough's opening statement, he informed the Board that he did not receive the request for records in April 2005 as alleged, or a letter in May. He still has not received the signed release form requesting medical records. Dr. Gough was puzzled by the fact that he received three letters, but yet he was alleged to have received four others. He was provided records from his attorney and there was no communication from October to December 2005. Dr. Gough noted that this was the first time he had ever been accused of failing to provide a patient with their records.

Dona Pardo, Ph.D., R.N. led the questioning. Dr. Gough stated that when he received a letter in March, it had no signed release form attached. He assumed that JC realized that he had not sent it and would eventually send a signed release form. He received another letter in April but this one was also missing the release form. At that time, Dr. Gough sought legal counsel. He was advised to submit a standard HIPAA release form for medical records to JC to have RN sign and return. Dr. Gough did not understand why JC submitted two requests for medical records with no signed release form. Dr. Gough stated that his former attorney, Mr. Westover, had advised him not to contact RN or her family.

Dr. Gough then stated that it was a little confusing after Mr. Westover sent the HIPAA form to JC. RN's signed release form was received by Mr. Westover the same day. The signature was dated a week later and the heading on the top of the release from was JC's rather than the patient's, RN, which meant that the letter had to have originated from the JC's office. Dr. Gough stated there was no evidence that the signed release form came directly from RN. Mr. Westover did not believe the release was valid and still advised Dr. Gough to not send the record. Mr. Westover then told Dr. Gough that he would contact JC and try to straighten out the situation.

Dr. Gough gave RN's records to Mr. Westover and no longer had the original. Dr. Gough tried contacting Mr. Westover after October 2005 and was told that he was in California and would get back to him. The last time Dr. Gough saw Mr. Westover, he went to Mr. Westover's office for a scheduled appointment but Mr. Westover cancelled. On January 5, 2006, Dr. Gough received a letter from JC stating Mr. Westover told him he was no longer representing Dr. Gough. JC requested the records be sent to him within the next ten days.

Dr. Pardo was concerned that as the physician, Dr. Gough was responsible for responding to a patient who requests his or her medical records, regardless of the lawyer's involvement. Dr. Gough stated that he was following orders from Mr. Westover because it was not clear to him that they had authorization from the patient.

Dr. Gough thought that RN was trying to sue him. She filed a lawsuit against Dr. Gough on March 1, 2006 for a brain tumor that Dr. Gough failed to diagnose, but never pursued it. Paul M. Petelin, Sr., M.D. felt Dr. Gough was trying to protect himself from a malpractice suit by not providing the records to the patient or attorney. It appeared to Dr. Petelin that the discovery of a brain tumor the size of a grapefruit in RN, whom he had been treating for eight years for Attention Deficit Disorder, may have had medical-legal implications against him. Dr. Gough disagreed and felt he did nothing wrong. He thought it was a very slow-growing tumor in a silent area of her brain and did not think there were many physicians that were going to find it either.

Robert P. Goldfarb, M.D. asked Board Staff if the quality of care issues were addressed during the course of the investigation. Staff addressed this case only as a records issue; the quality of care delivered had not been reviewed.

**MOTION: Douglas D. Lee, M.D. moved to go into executive session.**
**SECONDED: Dona Pardo, Ph.D., R.N.**
**Vote: 12-yay, 0-nay, 0-abstain, 0-recuse, 0-abstain.**
**MOTION PASSED.**

The Board went into Executive Session for legal advice at 1:42 p.m.
The Board returned to Open Session at 1:48 p.m.

No deliberations or discussions were made during Executive Session.

In his closing statements, Mr. Fadell stated that the bottom line is that the two attorneys did not communicate. Dr. Gough did not get the best legal advice that he should have received by relying on Mr. Westover. Mr. Fadell suggested this was a one time problem in Dr. Gough's practice.

Ms. Geiser pointed out inconsistencies in Dr. Gough's testimony compared to his licensee response he had previously submitted to the Board.

Dona Pardo, Ph.D., R.N. believed Dr. Gough had committed unprofessional conduct in that he failed to provide medical records to the patient upon request.

**MOTION: Dona Pardo, Ph.D., R.N. moved for a finding of unprofessional conduct under A.R.S. § 32-1401(27)(a) – Violating any federal or state laws, rules or regulations applicable to the practice of medicine and A.R.S. § 12-2293.**
**SECONDED: Lorraine Mackstaller, M.D.**
**Vote: 12-yay, 0-nay, 0-abstain, 0-recuse, 0-absent.**
**MOTION PASSED.**

In review of the records provided to the Board, Dr. Petelin was concerned with the quality of care delivered by Dr. Gough in this case.

**MOTION: Patrick N. Connell, M.D. moved to continue the matter to review the quality of care issues and bring the matter back to the Board.**
**SECONDED: Douglas D. Lee, M.D.**
**ROLL CALL VOTE: Roll call vote was taken and the following Board Members were in favor of the motion: Patrick N. Connell, M.D., Dan Eckstrom, Robert P. Goldfarb, M.D., Ram R. Krishna, M.D., Douglas D. Lee, M.D., Lorraine Mackstaller, M.D., William R. Martin, III, M.D., Dona Pardo, Ph.D., R.N., Paul M. Petelin, Sr., M.D., Germaine Proulx, and Amy J. Schneider, M.D.**
**MOTION PASSED.**

| NO. | CASE NO. | COMPLAINANT v PHYSICIAN | | LIC. # | RESOLUTION |
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| 6. | MD-06-0305A | AMB | ROBERT A. LEWIS, M.D. | 9878 | Dismiss. |

Robert A. Lewis, M.D. was present with counsel, Robert Milligan from the law firm Gallagher & Kennedy.

Drs. Connell, Goldfarb, and Martin stated they knew Mr. Milligan but did not feel it would affect their ability to adjudicate this case. Dr. Martin also knew Dr. Lewis but felt it would not interfere with his ability to adjudicate this case.

Erica Bouton, Senior Investigator summarized the case for the Board. Staff found Dr. Lewis failed to report the suspension of Dr. Timbadia's hospital privileges to the Board. Dr. Lewis believed this was not a reportable action.

In his opening statements, Dr. Lewis stated that the hospital attorney told him there was no requirement to report the surgeon's suspension to the Board since the case was pending review. After the review was over, Dr. Lewis again asked the hospital's attorney if it should be reported, the attorney told him it was not a reportable action. The new hospital attorney also assured him that the action did not need reporting. Even knowing what he knows now, Dr. Lewis stated he would still seek legal counsel prior to reporting any action to the Board.

Robert P. Goldfarb, M.D. led the questioning. Dr. Lewis is no longer the Chief of Staff at the hospital. He was Chief of the Executive Committee at that time. He was in this position for approximately six years. In his position, if a physician was only reviewed, it would go to the Executive Committee. If it were something more, it would be reported to the National Practitioner's Databank.

Dr. Lewis stated that the Committee would always consult with the hospital attorney before reporting. The peer review took six months before the Committee was able to lift the suspension. The Committee ordered a chaperone to be present during ten of Dr. Timbadia's cases, and the Committee felt they took an extra step toward patient safety in doing so. At the end of the review, the Committee consulted once again with the hospital attorney, and again was advised that it was not reportable.

Dr. Connell noted that the hospital attorney was not an Arizona attorney, and felt that was where the problem was.

In his closing statements, Mr. Milligan stated that if there was any uncertainty, he would have advised to report. Dr. Lewis never observed any evidence that the physician was ever unable to safely practice medicine. Dr. Lewis thought to only report when there was a patient care concern.

Robert P. Goldfarb, M.D. noted that from Dr. Lewis' explanation, there was never an effort to cover up the action; the hospital thought they were compliant. The hospital received the wrong information from the hospital attorney. Dr. Goldfarb noted that in October of 2006, Mr. Miller had sent a letter to hospital administrators trying to clarify the issue of reporting since there were a number of hospitals that were non-compliant.

**MOTION: Robert P. Goldfarb, M.D. moved for dismissal.**
**SECONDED: Patrick N. Connell, M.D.**

Ram R. Krishna, M.D. asked the Board if an Advisory Letter would help get the message out. Dr. Goldfarb understood Dr. Krishna's point but did not think that Dr. Lewis should be cited.

From a legal perspective, Ms. Cassetta stated that the language of the statute is very clear and broad in what is required to be reported and felt if a hospital went as far as taking away privileges to investigate an issue that would meet the threshold of the statute. She thought the language encompassed what happened in this case.

Dona Pardo, Ph.D., R.N. spoke against the motion. She noted that when Dr. Lewis was asked if he was aware of the statute, he said no. She was concerned that he was practicing but was not aware of the statutes. Lorraine Mackstaller, M.D. spoke in favor of the motion. She was concerned that the Board would end up making hospitals report physicians prematurely, before their investigation would be finished. Paul M. Petelin, Sr., M.D. also spoke in favor of the motion. He did not think Dr. Lewis should be disciplined for doing his job. He disagreed with Dr. Lee and Dr. Goldfarb and thought the statute is clear, it was not confusing. He stated the Board has an obligation to reeducate the people in leadership roles.

**ROLL CALL VOTE: Roll call vote was taken and the following Board Members were in favor of the motion: Patrick N. Connell, M.D., Dan Eckstrom, Robert P. Goldfarb, M.D., Patricia R.J. Griffen, Ram R. Krishna, M.D., Douglas D. Lee, M.D., Lorraine Mackstaller, M.D., William R. Martin, III, M.D., Paul M. Petelin, Sr., M.D., Germaine Proulx, and Amy J. Schneider, M.D. The following Board Member was against the motion: Dona Pardo, Ph.D., R.N.**
**Vote: 11-yay, 1-nay, 0-abstain, 0-recuse, 0-absent.**
**MOTION PASSED.**

William R. Martin, III, M.D. instructed the Executive Director to add mandatory reporting to the list of discussion items for the Board's offsite meeting.

| NO. | CASE NO. | COMPLAINANT v PHYSICIAN | | LIC. # | RESOLUTION |
|---|---|---|---|---|---|
| 7. | MD-05-0263A | J.K. | SCOTT C. FORRER, M.D. | 19296 | Draft Findings of Fact, Conclusions of Law and Order for Letter of Reprimand for failure to appropriately evaluate a patient with complaints of abdominal pain and performing unnecessary testing. |

Scott C. Forrer, M.D. was present with counsel, Brian Murphy from the law firm Burch & Cracchiolo.

Robert P. Goldfarb, M.D. recused himself from this case.

Carol Peairs,M.D., Medical Consultant summarized the case for the Board. Staff found that Dr. Forrer violated statute by initially denying his financial relationship with the vitamin salesman,.

During his opening statement, Dr. Forrer stated JK's chief complaint was not just abdominal pain, she enumerated numerous concerns. Mr. Bolwick was employed by Dr. Forrer for counseling patients in weight loss and nutritional health. Dr. Forrer informed the Board that Mr. Bolebruch no longer works for him.

William R. Martin, III, M.D. led the questioning. JK was referred to Dr. Forrer by Internist Andrew Johnston, M.D. and presented with internal pain. She thought she had a nerve problem. Dr. Forrer performed EMGs of all four extremities of the patient. He also ordered an MRI for the patient's entire spine. He wanted to make sure he was not missing anything. In a sense, Dr. Forrer stated that one could refer to his work up as a screening test.

Dr. Forrer went through the different diagnoses and checked them off through two office visits. During the course of the investigation, Dr. Forrer submitted a response to the Board stating he prescribed JK a dietary supplemental program that would have helped in reduction of weight, however, during the interview, Dr. Forrer stated that JK was not overweight. Dr. Forrer stated that there were other dimensions of the nutritional program that went with protein support to maintain weight and there was also nutrition for good health.

Dr. Forrer stated that Mr. Bolebruch was hired for the purpose to provide nutritional counseling with the emphasis being predominantly for individuals that would seek nutritional assistants from outside his office. Dr. Bolebruch was employed by Dr. Forrer part time. Dr. Forrer explained his financial relationship with Mr. Bolebruch to the Board.

Ram R. Krishna, M.D. addressed Dr. Forrer's medical recordkeeping and discussed the findings from the tests he performed on JK. Dr. Forrer stated that a lot of JK's symptoms were neurological. When recommending nutrition, Dr. Forrer had no background or lab values to show JK's deficiency.

William R. Martin, III, M.D. addressed Dr. Forrer's timeliness of his responses to the Board during the course of the investigation. Dr. Forrer stated that he put the records in a manila envelope and stamped and placed it in the mailbox. The package was returned to him stating it could not be sent since it weighed more than a pound. Dr. Forrer then sent it FedEx to the Board.

Lorraine Mackstaller, M.D. noted that JK clearly stat that after talking to Mr. Bolebruch, she could not tolerate the vitamins because of her multi-chemical allergies. Dr. Forrer stated he was not sure he knew what happened between JK and Mr. Bolebruch.

Dr. Forrer was completely aware of the type of product Mr. Bolebruch was recommending to patients. He noted it was not a prescription or a treatment plan; it was just a nutritional support product. The Board noted that Dr. Forrer was not a nutritionist and this should have been under the supervision of one.

In his closing statements, Mr. Murphy noted that Dr. Forrer subsequently received the report from Dr. Johnston after JK had already presented to Dr. Forrer's office. This was a puzzle Dr. Forrer tried to put together but did not succeed. Mr. Murphy noted that others before him did not succeed either. Mr. Murphy stated that the Board's materials did not include a response previously submitted in which Dr. Forrer went into detail of his financial relationship with Mr. Bolebruch.

Vicki Johansen, Senior Investigator informed the Board that the supplemental information Mr. Murphy referred to was in fact included in the Board's materials and that the Board did have all the material submitted by Dr. Forrer and his counsel.

William R. Martin, III, M.D. believed that when a patient comes to a physician's office, it is important to obtain a history and perform a physical examination addressing the basis of their chief complaint. It is appropriate for addition symptoms to be identified and pursued.

**MOTION: William R. Martin, III, M.D. moved for a finding of unprofessional conduct under A.R.S. § 32-1401(27)(q) – Any conduct that is or might be harmful or dangerous to the health of the patient or the public.**
**SECONDED: Patrick N. Connell, M.D.**
**11-yay, 0-nay, 0-abstain, 1-recuse, 0-absent.**
**MOTION PASSED.**

Dr. Martin stated that one mitigating factor would be that all patients vary by age and present with more than just one complaint. Often times they come in with a whole list of complaints.

**MOTION: William R. Martin, III, M.D.: moved for Draft Findings of Fact, Conclusions of Law and Order for Letter of Reprimand for failure to appropriately evaluate a patient with complaints of abdominal pain and performing unnecessary testing.**
**SECONDED: Patrick N. Connell, M.D.**
**ROLL CALL VOTE: Roll call vote was taken and the following Board Members were in favor of the motion: Patrick N. Connell, M.D., Dan Eckstrom, Patricia R.J. Griffen, Ram R. Krishna, M.D., Douglas D. Lee, M.D., William R. Martin, III, M.D., and Germaine Proulx. The following Board Members were against the motion: Lorraine Mackstaller, M.D., Paul M. Petelin, Sr., M.D., and Amy J. Schneider, M.D. The following Board Member abstained: Dona Pardo, Ph.D., R.N.**
**Vote: 7-yay, 3-nay, 1-abstain, 1-recuse, 0-absent.**
**MOTION PASSED.**

The meeting adjourned at 5:04 pm.

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Timothy C. Miller, J.D., Executive Director